General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dickson Chemist, 35 Mitchell Arcade, Rutherglen, GLASGOW, Lanarkshire, G73 2LS

Pharmacy reference: 1091065

Type of pharmacy: Community

Date of inspection: 13/03/2023

Pharmacy context

This pharmacy is in a shopping centre in the Glasgow suburb of Rutherglen and it provides a range of NHS and private services. These include dispensing NHS prescriptions and supplying medicines in multi-compartment compliance packs to help people take them properly. The pharmacy uses automated technology for dispensing. It provides the NHS Pharmacy First and Pharmacy First Plus services. The pharmacy mainly uses employed pharmacist independent prescribers for its private prescribing service. And this includes prescribing and supplying low dose naltrexone and weight loss treatments.

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 does not have robust procedures to ensure it adequately identifies and manages all the risks associated with the private prescribing services it is associated with. This includes not adequately assessing the risks with prescribing and supplying medicines to people living outside the UK. And not suitably managing the risks associated with the dispensing of prescriptions from third-party clinics.
		1.2	Standard not met	The pharmacy does not suitably audit and review its private prescribing and dispensing services to ensure the procedures for these services are followed. And to help ensure it identifies any trends requiring intervention. This includes for higher-risk and unlicensed medicines. And for prescriptions received from third-party clinics.
		1.6	Standard not met	The pharmacy does not keep complete prescribing consultation records for prescribers and the responsible pharmacist to access. It does not always keep accurate records of its higher-risk medicines as it must by law, as it does not always make register entries when it makes supplies.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy generally identifies and manages the risks with its services. But not always with its private services. And it doesn't have a process of review and audit for these. It doesn't keep complete prescribing consultation records for its private services. This means team members may not have all the information they need to help ensure people receive medicines that are suitable for them.
The pharmacy doesn't always keep accurate legal records. Team members protect people's confidential information. They discuss errors that occur, understanding what happened. And they take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Some SOPs were not clearly titled and several had not been reviewed for more than two years. This meant team members may not be following up-to-date procedures. For example, the SOPs for dispensing multi-compartment packs was developed in 2016 but hadn't been reviewed since that time. Other SOPs had been reviewed by the deputy superintendent pharmacist (SI) but they were not dated to show when this had happened. Team members had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. However, they had not fully followed the SOP for dispensing prescriptions issued by prescribers from the European Union (EU). The regular pharmacist explained how the company completed audits of the pharmacy's compliance with its procedures and how the pharmacy had passed a recent audit. However, evidence of the audit was not presented.

The pharmacy's private prescribing services were led by a small team of pharmacist independent prescribers (PIPs). Several private prescriptions were for low-dose naltrexone (LDN) for medical conditions on an agreed list, such as rheumatic disorders and chronic fatigue syndrome. People with medical conditions not on the agreed list were referred to more experienced prescribers. The use of LDN to treat these conditions was outside the manufacturer's license. The PIPs had completed specific training to prescribe LDN for these conditions and they had experience from previous roles. There was a risk assessment (RA) for this service that was reviewed in May 2022. But there was no audit of the service to ensure the safeguards implemented from the RA were being practiced or remained suitable. Most prescriptions were issued following a remote consultation with the person but the RA had not considered the risks with this. The RA required people to provide evidence such as a letter from their consultant of an existing diagnosis and any other prescribed medication. And evidence of this process being followed was seen. The information was reviewed by a prescriber. People were required to verify their identification by submitting a photograph of themselves holding photographic identification. A prescribing policy updated in November 2022 provided information on prescribing LDN and consultation points for the PIPs. This helped to ensure consistency in prescribing. The RA and prescribing policy didn't have review dates and hadn't been signed by the PIPs to acknowledge their understanding. A sample of LDN consultations and records found the initial documents requested as proof of medical diagnosis and the person's identification were not embedded in the system. They were kept separately as an email so it was not clear what information the PIP referred to when completing a consultation. There was limited information within the consultation entries and they contained general notes such as "dosing explained and common side effects." They did not reflect an individualised and complete prescribing consultation for an unlicensed medicine such as LDN. For example, there was no

documentation considering the person's medical condition in the consultation notes. This meant there was limited information available for future prescribing and for the responsible pharmacist (RP) to refer to when undertaking the clinical check of the prescription. Some consultations were for people based outside the UK and EU and these were held via a video link. The pharmacy had not considered guidance within the GPhC's "In-practice: guidance for pharmacist prescribers", or the General Medical Council's (GMC) guidance, "Good practice in prescribing and managing medicines and devices" when prescribing and supplying to people based outside the UK. The guidance states that the prescriber must consider how the person's medical condition will be monitored, the legal requirements each country may have for receiving LDN, whether the pharmacist's indemnity and insurance arrangements are adequate, and whether the prescriber requires to register with regulatory bodies in the country the patient is based. But the pharmacy could not provide evidence of any of these risks being considered or addressed.

There were some risk assessments and prescribing policies for other private services, including weight management and prescribing Sativex. But they didn't indicate when a review was due and were not signed and dated by the PIPs. A sample of consultation records and prescriptions issued by the PIPs found a small number of medicines such as Sativex and Ozempic prescribed for conditions outside the manufacturer's license. There was no evidence the PIPs had clarified there was a need for the medicines to be prescribed in this way. There was no RA and prescribing policy for Ozempic, an injection usually used for diabetes, but being prescribed outside the manufacturer's licence for weight loss. Plans were in place for the PIPs to prescribe esketamine, a licensed medicine initiated by a specialist for treating depression. But there was no clinical RA yet to show how this service would be provided safely and the PIP's responsibility for providing the service. The PIPs had not completed training relating to this and had not yet gained experience to enable them to safely prescribe this medication.

The PIP offered face-to-face consultations in the pharmacy to assess people for conditions including long-COVID and multiple sclerosis before referring them for hyperbaric oxygen therapy. This was completed in the hyperbaric oxygen chamber situated adjacent to the premises. People had a consultation with the PIP who checked the person wasn't taking any medication or had a medical condition that meant the treatment was inappropriate. But there were no clinical risk assessments or service audits to review treatment. People were given a therapy logbook, but no consultation record was retained within the pharmacy.

The pharmacy provided a dispensing service for private third-party clinics that offered specialist services including allergy clinics. The SI met with the clinicians from these clinics to understand their model of care and scope of practice and sometimes kept records of the discussions from these meetings. But the pharmacy did not have documented risk assessments to consider the risks associated with the specialist nature and off-label use of the medicines being provided. And the pharmacy didn't carry out ongoing checks on the registration status of the prescribers from these private clinics to ensure the prescriptions were valid. The pharmacy didn't audit its dispensing from these clinics to confirm the prescribers were adhering to clinical guidelines and that the medicines dispensed were suitable to supply. There were no ongoing checks on changes in prescribing at these clinics, including checks on scope of practice.

As part of the pharmacy's dispensing process, the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the error. Records were kept of these errors known as near misses and were usually completed by the pharmacist. This meant the team member missed the opportunity to capture their reflection on why it happened and how they'd prevent it from happening again. A separate near miss record was used by the team dispensing medicines into multi-compartment compliance packs. The details recorded on near miss records enabled patterns

to be identified and helped the team to prevent errors from happening again. Separate records were kept of errors identified after the person received their medicine, known as dispensing incidents. Team members discussed patterns from all errors and how to prevent them. For example, being alert to different forms of the same medication and to not assume the quantity of medicines in a split pack was correct. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And its website provided people with information on how to raise a concern and provide feedback.

The pharmacy had current professional indemnity insurance. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty and the RP record was appropriately maintained. The controlled drug (CD) registers were kept electronically, and the system captured the current stock balance for each CD register. This was checked against the physical stock after an entry was made to help identify issues such as missed entries. CD prescriptions dispensed and supplied weekly for people were not recorded as weekly supplies. The records showed the full quantity prescribed rather than the quantity supplied each week. A record of the weekly supply was made on the instalment prescription but not in the CD register. This meant that an accurate contemporaneous record was not reflected in the CD register. And the balance in the register did not always accurately reflect the quantity in stock. Any changes made by the RP in the CD register were tracked for audit purposes. The system included a pending section of the CD register that held details of the CD prescriptions before they were recorded in to the main CD register. This created an additional step in the process of recording, and it wasn't always clear from the information in the pending section when supplies had been made to people. The SOP for recording CD supplies had been recently updated but team members were unaware this and were working from an out-of-date version. The pharmacy kept a record of CDs returned by people for destruction. Team members had completed training about the General Data Protection Regulation (GDPR) and they separated confidential waste for shredding onsite. The pharmacy displayed a privacy notice.

The pharmacy had safeguarding procedures dated June 2020 for the team members to follow and it provided them with training. The RP was registered with the protecting vulnerable group (PVG) scheme and had responded well when a safeguarding concern arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team with a wide range of skills and experience. And they work efficiently in smaller teams supporting each other in their day-to-day work. The pharmacy offers ongoing training and development opportunities for all team members to progress in their role and improve their knowledge and skills. And it supports its pharmacist prescribers to share best practice and review their prescribing skills. Team members are encouraged to discuss ideas and implement new processes to enhance the delivery of the pharmacy's services.

Inspector's evidence

Pharmacy services were provided by a large team who mostly worked full time. The team consisted of a pharmacist independent prescriber (PIP) who was the deputy superintendent pharmacist, a regular pharmacist, a trainee pharmacist, an accuracy checking technician (ACT), six qualified dispensers one who was also a supervisor, two trainee dispensers and two delivery drivers. One of the dispensers was an accuracy checker (ACDA) and three dispensers were undertaking the ACDA training course. A warehouse operator supported the team with the ordering of stock and managed the stock in the automated dispensing system. This team member had received stock control training. But they hadn't completed training on other activities they were involved with such as assigning bar codes to unlicensed medicines. They didn't complete any dispensing activities requiring accredited qualification training. Most team members were on duty at the time of the inspection. Two part-time PIPs supported the private prescribing services, one worked at the pharmacy, the other worked remotely. One of the company directors was a dispenser and supported the team when required.

Team members worked well together and supported each other to ensure people presenting at the pharmacy counter were not kept waiting. Several team members had specific roles and responsibilities to assist with the delivery of the pharmacy services. And they supported colleagues in other areas when required. Team rotas and holidays were organised to ensure there was sufficient trained team members to support the different activities. The pharmacy used an external company for Human Resource support and provided team members with access to a mental health support programme.

Team members had some opportunities to develop their knowledge and skills through ongoing training and informal feedback on their performance. And they were given some protected time at work to complete their training. Specific training had been provided to team members responsible for using the automated dispensing system for dispensing compliance packs. And they'd gained knowledge from other colleagues working in these specialised roles. As the pharmacy's workload increased the need for more ACDAs was identified and team members wanting to develop their skills were enrolled onto the course.

The PIP attended peer review sessions with other prescribing pharmacists to review their current practice and develop their skills. They had identified limits to their own competence, and set limits on their practice, such as not prescribing for children under five years old. The PIPs who prescribed low dose naltrexone (LDN) had completed training provided by the LDN Research Trust which included a Masterclass exam. The superintendent pharmacist (SI) held meetings with the company employed PIPs to discuss governance arrangements, record keeping requirements and good practice points for certain conditions. And this was an opportunity for the PIPs to receive peer support and improve their

prescribing quality.

The pharmacy held regular team meetings but not all team members attended. Team members responsible for the supply of compliance packs did not attend the main dispensary team meetings but did hold their own meetings. Meetings notes were shared with the head office team and the SI regularly visited the pharmacy. Team members felt comfortable to suggest changes to processes or new ideas of working. The team dispensing compliance packs had introduced processes to ensure the service was efficiently delivered on time. This included a limit to the number of medicines that could be dispensed into the packs due to space limitations in the automated system. And they had a daily cut-off time for the receipt of prescriptions so there was time to deal with queries and still dispense the packs. The team held a training event for the other pharmacy teams to explain the processes and why they were introduced.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are an appropriate size for the services provided. And the pharmacy is suitably clean, hygienic, and secure. The pharmacy has good facilities to meet the needs of people requiring privacy when accessing its services.

Inspector's evidence

The pharmacy's dispensing services were provided across a main dispensary, a small room where multi-compartment compliance packs were dispensed and an upstairs room where private prescriptions were dispensed. There was plenty of workspace in all the rooms and team members kept the pharmacy tidy, free from clutter and it was hygienic. There were separate sinks for the preparation of medicines and hand washing with hot and cold water available. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. And there was hand sanitising gel for the team and people to use.

The pharmacy had an automated dispensing system to support the team's workload. This was housed in a separate room to the rear of the premises so it did not impact on the areas the team worked in. Room temperatures were comfortable throughout the premises and areas housing the automated dispensing systems were temperature controlled. UV lights and an air filtering unit were installed in the room where multi-compartment compliance packs were dispensed to protect medicines removed from their original packs. And to protect team members from any powder released from the medicines kept loosely within the automated system.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. Two consultation rooms were available. One was used exclusively by the PIP and was suitable for the services provided including a treatment couch. The team used the other room for private conversations with people and when the RP was providing services. This room was also well equipped to provide the services. A separate room accessed from the main shopping precinct provided privacy to people receiving their medication as a supervised dose. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a large range of private and NHS services, which are easily accessible and help people to meet their healthcare needs. It uses automation when dispensing to support the safe delivery of its services. Team members carry out checks to ensure medicines are in good condition and suitable to supply. The pharmacy generally has the safeguards it needs for the safe delivery of its private prescribing services.

Inspector's evidence

The pharmacy had level access from the shopping centre and car park which allowed people to easily enter the premises. There was sufficient room in the retail area for people to move around. The main dispensary faced the retail area so the team could identify anyone who needed assistance. People accessed information for both NHS and private services on the pharmacy's website. Team members asked appropriate questions of people requesting over-the-counter (OTC) medicines and they monitored people's requests to buy OTC medicines to ensure the supplies were suitable.

The NHS Pharmacy First and Pharmacy First Plus services were popular particularly for medical conditions such as urinary tract infections. And the team provided people with a range of medicines to treat minor ailments. The PIPs supporting the Pharmacy First Plus service worked to a national service specification and prescribed to a local formulary. They used NHS prescriptions with unique prescriber numbers so their prescribing activity could be reviewed and audited. People booked consultations using the pharmacy's online booking system. Or they could access the service when waiting in the pharmacy. The regular pharmacist referred people presenting at the pharmacy and was aware of the medical conditions the PIP could prescribe for and the limitations of the service. This helped prevent inappropriate referrals. Local GP teams were aware of the service and signposted people to the pharmacy. Pharmacists from other pharmacies within the company referred people for assessment. The service specification enabled the assessment to be sometimes carried out over the telephone. But certain conditions required a physical examination and were not suitable for remote consultation. The PIP contacted the referring pharmacy for information such as details of the medication the person was prescribed. The consultations were documented, and a summary was sent to the person's regular GP. Access to the person's GP records was not available for the PIP to check information such as people's blood results. When this information was needed the PIPs obtained the person's consent to contact their GP. The pharmacists also used a range of NHS Patient Group Directions (PGDs) to support the supply of prescription only medicines within the service. However, the pharmacists had not signed all the PGDs to show they understood and would follow them. Team members provided several people with their medicines from NHS instalment prescriptions. These were dispensed in advance of supply and stored separately in baskets labelled with the person's name.

The pharmacy had been involved in a service dispensing prescriptions issued by two prescribers based outside the UK who prescribed treatments for transgender people and gender dysphoria. The pharmacy had a completed risk assessment for the service. And it had stopped dispensing these prescriptions in February 2023 after re-assessing the risks with being associated with the prescribers based outside the UK.

The pharmacy's prescribing service was supported by three PIPs. Clinical checks were made by the RP

and they challenged prescribing decisions when needed. Records of interventions were seen, for example, suggesting a change to the dose of a medication based on the person's age. People accessed the private prescribing service via the pharmacy's website or by telephoning the pharmacy. The website provided information about some of the conditions the PIPs prescribed for and the treatments available.

People requesting treatment for low dose naltrexone (LDN) were commonly referred by clinicians with a specialist interest, or through the LDN Research Trust. People registered with the pharmacy to arrange a private consultation with a PIP and were given a unique username and password. Thirty-minute appointments were offered to allow the PIP time to fully complete the consultation. Consultations for LDN were mainly completed over the telephone, but also by video call or in person. Prescriptions were generated in the system and could not be amended once created. People could see a copy of the prescription and could access their account to order further prescriptions and make payments. Each prescription for LDN contained the text "To be dispensed only by Dickson Chemist unless accompanied by an ink signature." This helped prevent copies being dispensed at other pharmacies. The PIP didn't inform the person's regular prescriber that LDN was prescribed. People were advised to make their GP aware, but the pharmacy didn't check if this was done. People receiving LDN for the first time were supplied with an information pack produced by the LDN Research Trust. This contained frequently asked questions and reference sources. Prescriptions covered a three-month period and were dispensed in monthly instalments. Further supplies were made after the PIP completed a three-month review with the person. This was because the benefits from taking the medication were usually seen at three months. The pharmacy team provided people with clear advice on how to use their medicines. Every prescription for LDN was supplied with a patient information leaflet. This provided details of the unlicensed use of the medicine, how to use and store the medication, the medicine's ingredients and information on the manufacturer.

The pharmacy provided NHS dispensing services. It supplied medicine to several people daily as supervised and unsupervised doses and used automation with a pump linked to a laptop to prepare the doses. The team inputted prescription data into the system on the laptop to ensure the pump measured the required doses and printed labels. Team members regularly checked and cleaned the pump to ensure the correct doses were measured on each occasion. But they did not record the details of who had completed these checks. The team asked the person to confirm their name and the dose they were expecting to ensure the correct dose was supplied to the person.

The pharmacy provided multi-compartment compliance packs to a large number of people to help them take their medication. And it provided the service as a hub dispensary for other pharmacies in the company, which were known as spoke pharmacies. A dedicated team managed this process and used an automated dispensing system for most of the packs. Team members worked several days in advance of supply to allow for issues such as delays with prescriptions and faults with the automated system. Prescriptions were clinically assessed by a pharmacist at the spoke pharmacy, who determined if the medication was suitable for the automated system. Medication such as CDs and medicines that should remain in the original packaging were either dispensed manually by team members or the prescription returned to the spoke pharmacy. But when prescribers had requested medicines that normally remained in the manufacturer's original pack to supplied in a compliance pack the team had not kept a record of the decision. And the date these medicines were removed from the original packs and added to the automated system was not recorded. During the inspection, the ACT removed this type of medicine from the automated system for the team to manually dispense.

Prescriptions with more than 14 medicines were dispensed at the spoke pharmacy due to the time taken to dispense these items. And the risk that large numbers of medicines may fall into the wrong section of the compliance pack. Similarly, large-sized medicines were not added to the system. The

system generated a bar code for each prescription, which team members scanned at each stage of the process to help identify any errors. The team stored medicines in plastic containers ready to add to the system. Containers held medicines taken from the same batch and they were labelled with details of the medication, batch number and expiry date. This information was inputted into the automated system to confirm the medication was in date. Packs dispensed by the automated system were initially checked by a dispenser before a final check was completed by the ACT. The packs were appropriately labelled and descriptions of the medicines within the packs were included so that people could identify their medicines. However, the manufacturer's information leaflets were not routinely supplied. This meant people would not have all the information available about the medicines in the packs.

Most NHS prescriptions for medicines not supplied in compliance packs were dispensed from an automated dispensing system that the team accessed from computer work stations linked to the system. Each station had a chute leading from the dispensing system to a basket in the workstation. Team members used baskets to keep people's medicines with the correct prescription during the dispensing process. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. And a sample found the team completed both boxes. Team members marked prescriptions for CDs, to prompt them to check that supplies were made within the 28-day legal limit. And they used clear bags to hold dispensed fridge medicines to allow the team, and the person collecting the medication, to check the supply. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be given to people. A recent company audit highlighted the process could be improved and team members had been reminded of what was expected in a meeting.

The pharmacy kept a record of the delivery of medicines for the team to refer to when queries arose. And it kept a list of people who received their medication on specific days. An application embedded on a smart phone recorded the deliveries due each day so the driver could plan their route. Information such as fridge items and CDs was added to the application. Team members accessed the system to track the progress of the deliveries and check the receipt when queries arose.

The pharmacy obtained medication from several reputable sources. Unlicensed medication received at the pharmacy was assigned a bar code so it could be tracked. Trained pharmacy team members prepared LDN oral solution for prescriptions using LDN capsules supplied by a specialist manufacturing company. They recorded the batch numbers of the LDN capsules used and followed worksheets for preparing the solution. These detailed each ingredient required, the quantity to be used and the method for preparation. Records were kept of each batch prepared, including the date and initials of the team member and pharmacist who had checked the ingredients. To ensure the procedures for preparing the LDN solution were correct a batch of prepared solution had been previously sent for analysis by an external laboratory. This showed the concentration was within the expected and acceptable range. And confirmed stability for twelve months at room temperature.

Team members stored medicines tidily on shelves in the dispensaries. The automated dispensing system enabled spilt packs to be added, which were prioritised for dispensing and helped to keep the dispensary shelves tidy. The system captured the expiry dates of medicines as they were scanned. This ensured medicines with short expiry dates were picked first and alerted the team to medicines due to expire. Team members checked the expiry dates of stock not kept in the system and kept a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date. The dates of opening were recorded for medicines with altered shelf-lives after opening, so the team could assess if the medication was still safe to use. Team members checked fridge temperatures and a record was kept of the readings. A sample of these records found they were within the correct range but there were a few days when the reading hadn't been recorded. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and

patient returned CDs separate from in-date stock in CD cabinets that met legal requirements. The team had denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via an internal communication platform. The alerts were actioned by the team and a record kept of this activity. Team members followed a documented process when people reported an issue with LDN.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has a range of equipment and automation that it keeps well maintained to help ensure the safe and effective supply of medicines for people. And its systems suitably protect people's private information.

Inspector's evidence

Team members preparing the LDN oral solution used equipment that was washed at a high temperature in an automatic dishwasher following use. The pharmacy had a separate area and a filtration cabinet for safely preparing the LDN solution. There was an ongoing service contract for the cabinet and for the automated dispensing systems which included regular cleaning and maintenance. IT support was available for the automated dispensing systems which generally provided a same day response. The pharmacy's warehouse operator had some training on the automated system and could fix minor problems. And he could pause the system to enable the team to safely enter the area when manually picking medicines.

The pharmacy's computer screens were positioned so they could not be seen by unauthorised people and access to them was protected by passwords. It had cordless telephones so team members conversations with people could be held in private. Prescriptions awaiting collection were stored in dedicated drawers to ensure people's confidential information was kept secure. The pharmacy held other private information in the dispensary and rear areas, which had restricted public access.

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. It had a range of CE equipment to accurately measure liquid medication. And a fridge with a glass door that enabled the team to view the stock held without prolong opening of the door.

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.