General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Halliwell Midnight Pharmacy, 34 Halliwell Road, BOLTON, Lancashire, BL1 3QS

Pharmacy reference: 1099351

Type of pharmacy: Community

Date of inspection: 29/03/2021

Pharmacy context

This is a busy pharmacy located on a main road close to the centre of town. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy also provides an online prescribing service (www.prescriptiondoctor.com). The prescriber is an Italian doctor and the prescribing service is based in Romania. People can request a prescription by filling in an online questionnaire which is then assessed by the prescriber and pharmacist before the pharmacy supplies the medicine. The website offers prescription medicines for a wide range of conditions. The inspection was undertaken during the COVID-19 pandemic.

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's risk assessments do not identify all of the risks associated with the prescribing service or clearly explain how risks are managed. And it does not complete effective risk assessments when it introduces new treatment options or medicines to make sure the service the pharmacy provides is safe.
		1.2	Standard not met	The pharmacy does not actively audit or review the prescribing service and adherence to prescribing polices, to make sure and show it is safe.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website is arranged so that a person selects a prescription only medicine (POM) before starting a consultation with a prescriber. And the website does not contain clear and accurate information about the prescriber to enable people to make an informed choice.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy is not able to demonstrate that safeguards are consistently used to make sure the medicines it supplies through the prescribing service are clinically appropriate. This includes:- verifying the information provided by the person completing the online questionnaire, sharing all relevant information about the prescription with the patient's regular doctor and ensuring effective monitoring is in place.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

Whilst the pharmacy has made some changes and improvements to its online prescribing service, it does not consistently manage all of the associated risks. This means people might be able to obtain medicines which are not always appropriate for their needs. The pharmacy works with a prescribing service based in Europe, so it is not registered or monitored by a UK healthcare regulator. And the pharmacy does not regularly audit or review the prescribing service to make sure it is safe and in line with UK guidelines. The pharmacy manages its NHS services reasonably safely. Pharmacy team members generally work to professional standards and they keep the records required by law. But the pharmacy has not updated its written procedures for several years, so the pharmacy team might not always work as effectively as it could do. And some team members have not completed formal training on confidentiality and data protection, and they might not fully understand their role in keeping people's information safe.

Inspector's evidence

In addition to NHS prescriptions, the pharmacy also supplied a large number of prescription only medicines (POMs) on private prescriptions to patients in the UK through its website (www.prescriptiondoctor.com). Medicines were supplied against private prescriptions issued by a doctor. The doctor resided in Italy but he worked for an agency based in Romania and this address was on the prescriptions. The doctor was registered with the General Medical Council (GMC) but he was not licensed to practice in the UK and the prescribing service was not registered or inspected by a UK based healthcare regulator as it was located in Europe. The pharmacist superintendent (SI) confirmed that he had reviewed this business model in light of the UK no longer being part of the EU and he considered it was still an acceptable arrangement.

The pharmacy's prescribing service used the same prescriber to generate all of the prescriptions and the prescribing service could only be accessed via their website, Prescriptiondoctor.com. All prescriptions generated by the website were dispensed exclusively by the pharmacy. The pharmacy did not routinely supply prescriptions issued by other online prescribing services. Prescriptions supplied from the Prescription doctor website covered a wide range of medicines including Saxenda injections and Mysimba for weight loss, asthma inhalers, antibiotics for sexually transmitted diseases (STDs) and acne, levothyroxine, propranolol, Testogel, contraceptives, HIV PrEP (pre-exposure prophylaxis) and treatment for erectile dysfunction (ED). The pharmacy used Google optimisation to promote the website. The current focus was on weight loss and a large number of Saxenda injections had been supplied.

Prescriptions were issued electronically through a specialised computer system. The prescriber had his own access to the computer system and his IP address was shown on the prescription and checked to ensure the prescription was authentic. The pharmacy team used printed copies of the private prescriptions when assembling medicines. This activity was carried out during the afternoon. When they had been checked by the pharmacist, a packing assistant packed the prescriptions up and placed them in mail bags which were sealed ready for collection by Royal Mail each day. This process was outlined in the pharmacy's procedures.

There was an order processing guide which outlined how the team processed the requests for medicines. Duplicate accounts were identified by the customer service team checking IP addresses, email address, billing address, payment method and shipping address against their registered address. There was an identity (ID) policy and all people using the Prescription doctor service had their ID checked by a third-party provider. This checked the person's ID by name, address and date of birth. For certain medicines or if the person failed the third-party ID check, then the pharmacy would ask for further proof of ID by means of passport or driving licence. However, there was no face to face interaction to confirm ID, so this did not prevent a person using somebody else's identity, with or without their consent. This was a possible safeguarding concern as a child could potentially use their parents ID, or a vulnerable person could obtain medicines using another person's ID.

There were medication ordering alerts built into the prescribing portal which was programmed to alert when orders were placed sooner than the expiry of set time limits for certain medicines. This was intended to prevent people from ordering too many medicines. However, the pharmacy didn't carry out audits to ensure that these order limits were adhered to, and some inconsistencies were found during the inspection. Reorder time limits were set for asthma inhalers with a maximum of three inhalers on each prescription and no more than one inhaler per month. So, if three inhalers were prescribed, then another prescription would not be issued for three months. This was outlined in the pharmacy's 'Guidance on the prescribing of inhalers'. An example was seen of a patient who had been prescribed three Salamol inhalers on 24 July 2020. When they requested three more in September 2020, the prescriber declined the order and expressed that the person was not eligible to order more inhalers until 16 October 2020. The person was given the option to cancel the order but chose to wait for the supply to be made on 16 October. The same person requested an additional three Salamol inhalers on 19 November 2020, which was again 'too early', but this time the supply was made. Following the inspection, the administrator manager at Prescription doctor advised the inspector that they had contacted their IT developers about this breach, so it could be looked into.

Other examples of possible over-ordering of medicines were seen. For example, in relation to Testogel 88g pumps which deliver 60 doses, with a maximum dose of 4 doses per day, meaning at maximum use one pump should last 15 days. However, two examples were seen of repeat supplies being made after only eight days. In addition, 18mg Saxenda pens which have a maximum daily dose of 3mg, meaning one pen should last at least 6 days. However, there were several examples seen when people were prescribed five, seven or even ten pens and then received further supplies a couple of weeks later. This kind of activity was not audited.

People requesting prescription medicines from the prescribing service were asked a series of questions and their responses were sent to the prescriber for approval before a supply was made. The response could be viewed by both the pharmacy and the prescriber and key questions were highlighted in red. Patients using the prescribing service communicated with the prescriber, pharmacy or customer service team via a chat messaging system and all the messages could be viewed by the prescriber, customer service team and pharmacist. 'Tags' were applied to patient's records building up a profile of the person and included:- 'evidence uploaded,' 'early order', 'LN or EQ (ID) verified', 'review symptoms/therapy before next order'. Examples were seen of requests which had been refused, either by the prescriber or pharmacist. People were required to provide proof of asthma status or evidence from their GP if ordering 'too often'. One example was seen where an order for inhalers had been declined as the patient's Summary Care Record (SCR) did not confirm a diagnosis of asthma or use of inhalers. One example was seen when a request for 14 trimethoprim was changed to 6 Macrobid (nitrofurantoin) by the prescriber in keeping with both NICE and local antibiotic guidelines (resistance to trimethoprim) for uncomplicated cystitis.

There were clinical governance guidelines signed by the prescriber dated 4 August 2017 and reviewed

in April 2019. This included a statement that notes should be securely sent to the patient's registered doctor to advise on information received from the patient and inform them of treatment supplied by Prescription doctor. This was intended to ensure the patient was giving the correct information to the remote prescriber, receiving the correct treatment and not being under or over treated. Prescription doctor had appointed a clinical lead in November 2019 and his role and responsibilities were set out in an agreement. Reviews and audits were included as part of his role, however the Prescription doctor team were only able to provide one example of an audit which had been completed since the clinical lead was appointed. This was a review of 127 prescriptions in a one-week period in January 2020. The audit concluded that all 127 prescriptions met with UK prescribing guidelines in terms of strength, dosage and quantity. An action point was that any new medications initiated as part of the prescribing service would be subject to individual risk assessments, however this had not been done for new medicines introduced since the audit, which included Saxenda and HIV PReP. The assessment questionnaires and prescribing guidelines were developed jointly by the prescriber, SI and the administrator manager, and had been reviewed by the clinical lead. The IT system was sophisticated but did not seem to be used effectively to evaluate the quality of the prescribing activities. The IT manager could not provide information on the percentage of patients who had given permission for their GPs to be contacted or the percentage of people giving consent for their SCR to be viewed. This had not been audited. However, as part of the January 2020 audit, it was identified that three prescriptions for levothyroxine had been issued and SCRs had been viewed for all three of these patients to confirm the dose.

A risk assessment for the prescribing service had been implemented on 23 September 2019 by the IT and administrator managers, in response to the new GPhC Guidance for Registered Pharmacies Providing Services at a Distance. However, this had not been updated when new medicines such as Saxenda were introduced to the prescribing service. The safeguarding risk of supplying products for weight loss, without physical examination, to vulnerable people with eating disorders did not appear to have been considered. And there was no way of assessing a patient's mental capacity, to determine whether a remote consultation was appropriate. The risk assessment included website and data security. There was an IT security policy dated March 2019 with a statement that the user agreed to comply fully with the Company's Data Protection Policy and the General Date Protection Regulation. (GDPR).

There were standard operating procedures (SOPs) for the pharmacy's services which were prepared in March 2014. Their stated period of review was every 12 months but there was no documented review, so they may not reflect current practice. The superintendent (SI) was in the process of updating the SOPs but was yet to complete this. There were signatures for some members of the pharmacy team to indicate they had read and understood the SOPs, but some current members of the team had not signed them. A dispenser who had not signed the SOPs confirmed he had read them. There were separate folders of policies and standard operating procedures (SOPs) for the Prescription doctor prescribing service.

Near miss records were available in paper form, but the last record was made in January 2020, so team members may be missing out on some learning opportunities. The responsible pharmacist (RP) explained that they were going to use an electronic system to record and review errors going forward, but no records had been made on this yet. The SI said he discussed near miss errors with members of the pharmacy team when they were found and the person responsible was asked to rectify it. Some anecdotal examples were provided of action taken to help prevent near miss errors, such as segregating stock. A dispensing incidents record was seen on one patient's medication records. The SI said this had been reported to the National Reporting and Learning System (NRLS) and discussed with members of the pharmacy team.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A medicine counter assistant (MCA) was able to describe their responsibilities and provided some examples of what could and could not be carried out during the absence of a pharmacist. Staff did not usually wear uniforms or anything to indicate their role, so this might not be clear to members of the public.

The pharmacy had a complaints procedure which included recording the issue and referring it to SI to be followed up. There were no details about the procedure on display, so people might not know how to raise a concern or give feedback. The Prescription doctor website gave the contact details of customer service and there was a form to report complaints on. They used trust pilot to monitor customer service and had 4.7 out of 5 rating.

A current certificate of professional indemnity insurance was on display in the pharmacy. This SI confirmed that this covered the pharmacy's internet business and the insurance provider was aware that they used a remote prescriber in the EU. Following the inspection, the SI provided a current certificate of good standing from the relevant medical board in Italy stating the prescriber was registered and without disciplinary sanctions pending. He also provided a current insurance certificate for the prescriber which indicated a level of indemnity of around five million Euros.

The RP was correctly signed into the RP register. Records for controlled drugs (CDs) were maintained electronically and running balances were recorded. A balance check had taken place on the day prior to the inspection, and there were some discrepancies found. Following investigation these were found to be due to missing entries from as far back as 2019. This indicated the records were not always made accurately and kept up to date. Two random balances were checked, and both found to be correct. Records for emergency supplies and unlicensed specials appeared to be in order. Some private prescriptions had been dispensed from faxes but had not been reconciled with the original prescriptions. The SI said he would ensure this was done and any outstanding original prescriptions would be obtained.

The SI said he contracted the completion of information governance policies out, and he was unaware where the policy was kept, or if people had signed it. This was a risk as some members of the team might not have completed the relevant training. A dispenser said he was informed about the need for confidentiality when he started working in the pharmacy, but he had not read a policy or signed a confidentiality agreement. He correctly described what confidential information was and explained how it was segregated and removed by a waste carrier. But not all confidential information was stored as securely as it could be. Information about the pharmacy's privacy policy, and how people's information was handled and stored was available on the Prescription doctor website.

Historical safeguarding procedures written by the Royal Pharmaceutical Society of Great Britain (RPSGB) were available in the SOP folder. The RP and SI both said they had completed level 2 Centre for Pharmacy Postgraduate Education (CPPE) safeguarding training. A dispenser said she would report any concerns to the pharmacist on duty. Contact details of the local safeguarding board were not immediately available, so this might result in a delay in reporting safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload and the pharmacy team members are qualified for the jobs they do. The team members work well together, and they are comfortable providing feedback to their manager. But training is not provided in a structured or consistent manner. So, individual learning and development needs may not always be fully addressed.

Inspector's evidence

The SI, a regular locum pharmacist (RP), four NVQ2 qualified dispensers (or equivalent), a medicines counter assistant (MCA) and an unqualified member of staff were on duty in the pharmacy at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the patients. The unqualified member of staff said she did not work in the dispensary but carried out solely administrative duties such as contacting patients to check their prescription requirements before ordering their repeat prescriptions. The pharmacy usually operated 100 hours each week, but this had been reduced to 72 hours each week (9am to 9pm Monday to Saturday) due to staffing/workload pressures as a result of the pandemic. There was a large pharmacy team and some part-time staff who worked flexible hours. This, along with the reduction in opening hours, helped ensure adequate staff levels.

The MCA said she had completed some training during the previous year, but she only had limited opportunity to do this due to the increased workload caused by the pandemic. Her training records were not at the pharmacy as she had been working on them at home. A dispenser said she had been given some training time to complete coursework during the previous year. The RP said he felt able to exercise his professional judgment and this was respected by the SI. He said he was under no pressure to supply medicines which he wasn’t comfortable with. A dispenser said she felt there was a good level of support from the pharmacists and she said she was comfortable talking to the pharmacist or the SI about any concerns she might have. She said the pharmacy team had a group discussion at least once a month.

There was an IT manager, an administrator manager and a content manager in a separate room above the pharmacy where the Prescription doctor prescribing service operated from. The administrator manager was a pharmacy graduate so had a good understanding of pharmacy.

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

Summary findings

The premises generally provide a professional environment for people to receive healthcare. But the pharmacy uses a website that allows people to select the prescription only medicines they want before they have a consultation with a prescriber. This is not appropriate as it means people may not receive the most suitable treatment option for their needs. Information about the prescriber's registration is misleading and people may not have enough information to make an informed decision about their care.

Inspector's evidence

The pharmacy premises including the shop front and facia were in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to the SI who organised the required work, and the response time was appropriate to the nature of the issue.

The MCA described additional measures the team had introduced to ensure social distancing and infection control, in light of the coronavirus pandemic. She explained there had been an increases focus on hygiene and cleaning in the pharmacy, and she cleaned the medicine counter and payment device regularly. There were information notices about COVID-19 and reminders of the requirement to maintain social distancing. There were barriers to ensure adequate space in front of the medicine counter and the number of people in the pharmacy was restricted to two at any time.

There was a separate room on the first floor where excess stock was stored and the multi-compartment compliance packs for patients in care homes were assembled and stored. Staff facilities included a small kitchen and a WC with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was large, but it was cluttered with paperwork and multi-compartment compliance packs. It did not present a professional image. The RP explained they used this room when carrying out some services and when customers needed a private area to talk. He was observed using the room several time during the inspection, for example when carrying out an emergency hormone contraception (EHC) consultation. Some elements of the EHC service and smoking cessation service were carried out via the telephone to reduce the time each person spent in the pharmacy.

The website contained the voluntary GPhC logo. The name and physical address of the pharmacy was displayed on the website and the registration status of the pharmacy could be found by following the link from the GPhC logo. The website also contained the MHRA internet logo, however this was confusing as it was no longer active. The website displayed the name and a photograph of the medical prescriber, however their address, the country they were registered in and their indemnity arrangements were not made clear. The website was misleading as it stated the prescriber worked under the GMC when he worked in the UK, but although the prescriber was registered with the GMC he was not licensed to practice in the UK and the prescribing service was not regulated by UK healthcare regulators. People using the service were required to confirm as part of the questionnaire 'You are happy for your consultation to be reviewed by a European doctor company, and as such it is not subject

to CQC Registration'.

The website was arranged so that people selected the prescription only medicine (POM) before filling in the consultation questions. Under each condition the different names of products were shown and their starting price, but it was possible to start the consultation from the medicine itself, rather than from the condition. This was not in line with GPhC guidance and means people may not always receive the most suitable medicines for their needs. Some terminology was transactional such as 'Start order' which detracted from the professional image of the website.

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

Summary findings

The pharmacy does not always make enough checks to ensure medicines obtained through the prescribing service are appropriate for the people they supply. And it supplies some medicines which may not be appropriate for supply via a remote consultation because they require physical examination, blood tests or monitoring. The pharmacy often supplies medicines without informing the patient's regular doctor. This means their condition might not be properly monitored, and their use of medication may not be adequately controlled. The pharmacy offers a range of other healthcare services, which are suitably managed, so people receive appropriate care. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. Some services were advertised in the window such as flu and travel vaccinations, but other services were not advertised, so people might not know they were offered. There was a small range of healthcare leaflets and some information on healthy living.

Information on medical conditions and the medicines available through the Prescription doctor prescribing service was available on the website. Some of the medicines that the pharmacy issued prescriptions for were for chronic conditions which required monitoring and laboratory investigations to inform the progress and continuation of treatment and ensure the safe and effective delivery of care. The pharmacy prescribing pathways for Saxenda, Mysimba, asthma inhalers, levothyroxine and Testogel indicated that the prescriber should monitor and check laboratory results before issuing prescriptions. However, some patients were identified who were receiving these medicines on regular basis without the appropriate monitoring. Inconsistent practices were seen that were against the pharmacy's own local policies such as issuing prescriptions without confirming the patient's drug histories through their SCR or by contacting their GP, breaches of order limits, and issuing medicines without ensuring that the patient was being appropriately monitored.

There were prescribing pathways for medications which formed the algorithm for the questionnaire and fed into the prescribing platform. The assessment questionnaires contained two parts. The first part was standardised for all medicines and the second part of the questionnaire was specific for individual medicines. Patient consent to share information with their GP and access to SCRs was requested in most of the questionnaires, but providing consent was not mandatory. An example was seen of a patient who had been prescribed Saxenda and had given consent to inform their GP. The IT manager was not able to demonstrate that the GP had been notified, although he said this was done automatically. Neither the IT manager nor the administrator manager knew what percentage of people provided consent to share information or provided their GP details, and this had not been audited. The pharmacy was able to access SCRs with the patients' consent, however the patient's SCR was not viewed every time consent was given. The Prescription doctor team explained that this would be too time consuming, but the prescriber could request that the pharmacist check the SCR if he felt it was necessary. One example was seen for levothyroxine when the previous medication label had been uploaded and a screen shot of the patient's SCR had been attached for the prescriber to check.

People were not prescribed Saxenda unless their body mass index (BMI) was greater than 30 (or 27 with co-morbidities) and people were required to enter their height and weight as part of the questionnaire. This information was required to be updated at every order as part of the questionnaire, however there was no way of verifying that this information was correct, so there was nothing to prevent people entering incorrect information either accidentally or deliberately in order to receive the medication. One example was seen when the BMI was not available after three months use of Saxenda, so the prescriber requested an update of the weight for a patient during a review. However, some repeat prescriptions were identified where Saxenda was prescribed when the patient's BMI hadn't changed, which was an essential criterion for the continuation of treatment. The IT manager explained that a feature was being added which would automatically monitor weight (and BMI) using algorithms, rather than relying on manual monitoring. Diet and exercise advice including a booklet was supplied for people prescribed Saxenda and people were encouraged to get in touch with the pharmacy or prescriber with any queries.

When prescribing Testogel, testosterone levels were requested, and two examples were seen when pathology reports from a partner laboratory were provided as evidence of low testosterone levels. However, another example was seen when the patient's name and the date were not visible on their letter from a consultant confirming their testosterone levels, and supplies were still made. Some prescriptions were identified where Testogel was supplied while the patients had normal testosterone levels.

There was a delivery service for NHS prescriptions. A delivery record was kept of successful deliveries. Due to the COVID-19 pandemic, the delivery process had been altered to ensure it was meeting government guidelines. This included ringing the bell, placing the delivery bag on the floor before stepping back for the person to pick it up. If a person was not home to accept the delivery, the bag would be brought back to the pharmacy with a delivery note posted through the letterbox. There was a medication delivery policy for the posting of private prescriptions from the Prescription doctor service using Royal Mail. This was a 'signed for' service which could be tracked by the customer service team in the pharmacy.

Space was adequate in the dispensary, but the workflow was not well organised. Some of the dispensary shelves were full and untidy. Dispensed by and checked by boxes were initialled on some medication labels to provide an audit trail. But this was not the case for some medicines which had been dispensed in multi-compartment compliance aid packs for care homes, limiting the information available if there was an error. Stickers were put on assembled prescription bags in the pharmacy to indicate when a fridge line or CD was prescribed. The RP said he would use stickers to identify patients he wanted to counsel during collection of medicines, but these were not seen in use.

A large number of multi-compartment compliance aid packs were assembled in the pharmacy. There were around 75 care homes patients and around 100 community patients. Information about which medicines to order for care home patients was provided to the pharmacy by the care home staff. This information was used by the pharmacy to order the prescription from the GP surgery and ensure all of the prescriptions requested had been received by the pharmacy. For community patients, there was only a partial audit trail for changes to medication, so it was not always clear who had confirmed the changes and the date the changes had been made. Packaging leaflets were not usually supplied so patients and their carers might not have all the required information to take them medicine safely and effectively.

An MCA was observed selling medicines over the counter during the inspection. The questions asked were appropriate for the medicine being sold and she referred the patient to a pharmacist when needed. Pharmacy medicines were stored behind the medicine counter so that sales could be

controlled. A decision had been made to stop selling codeine linctus from the pharmacy around a year ago, due to the risk of abuse.

There were two medical fridges, a large one where most of the stock was stored and a smaller fridge in the consultation room where vaccinations and stock for Prescription doctor were stored. Both fridges had a built-in thermometer which was within 2-8-degree Celsius range during the inspection. Records indicated the minimum and maximum temperatures were being monitored regularly for both fridges.

Licensed wholesalers were used for the supply of medicines and appropriate records were usually maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The RP said that date checking was undertaken periodically, and some stickers were in place in the dispensary to alert people to short dated stock. A spot check did not find any out-of-date stock. An unlabelled bottle of tablets was found on the dispensary shelves with no information about its contents, which increased the risk of an error. These tablets were destroyed when they were brought to the attention of the RP.

Drug recalls were received electronically as part of the electronic CD register system. The RP said these were routinely checked for any affected stock. But there were no records made so the pharmacy may not be able to provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

Team members working in the pharmacy routinely wore face masks and had spare masks available for customers if required. Hand sanitizer was available. The pharmacy team could access the internet for the most up-to-date information. For example, the electronic British National Formulary (BNF) and medicines compendium (eMC) websites. Electrical equipment appeared to be in good working order. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were used for methadone solution. These used to be marked but the markings had worn off. The RP knew by the shape of the measures which ones to use for general dispensing, such as reconstituting antibiotics, but this might not be clear to all pharmacy team members. The pharmacy had a small range of clean equipment for counting loose tablets. There was a separate marked tablet triangle for cytotoxic drugs to reduce the risk of contamination. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.