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: 12/04/2022

Pharmacy context

This is a busy pharmacy located on a main road close to the centre of town. The pharmacy dispenses NHS prescriptions and it sells a range of over-the-counter medicines. It supplies a large number of prescription medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy also has a private prescribing service which people can access from its website www.prescriptiondoctor.com. It is a pharmacist led prescribing service, so it is not regulated by the Care Quality Commission (CQC). 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. In particular, the pharmacy does not effectively manage the risks in relation to the supply of asthma, weight loss and anxiety medication.
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 uses wording that gives people the impression that they can choose a prescription only medicine before having an appropriate 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 sufficient safeguards are in place to make sure the medicines it supplies through the prescribing service are clinically appropriate. It does not effectively verify the information provided by the person completing the online questionnaire, or share all relevant information with the patient's regular doctor or ensure that effective monitoring is in place. This is of particular concern when supplying medicines for chronic conditions such as asthma, weight loss and anxiety, when monitoring is crucial.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not consistently manage the risks associated with the prescribing service. This means people might be able to obtain medicines which are not always appropriate for their needs and could cause them harm. The pharmacy carries out audits of the prescribing practice, however, inconsistencies found in both the working practices and the quality of the service are not always effectively managed and addressed. The pharmacy manages its NHS services reasonably safely and it generally keeps the records required by law. But some pharmacy team members have not completed formal training on safeguarding, confidentiality and data protection, so they might not fully understand their role in safeguarding people and keeping people's information safe.

Inspector's evidence

There were standard operating procedures (SOPs) for the pharmacy's services which had been updated in August 2021. Roles and responsibilities of the pharmacy team were described in individual SOPs. A number of the SOPs had not been signed by the current team members. This included the SOP relating to working in the absence of a responsible pharmacist (RP). And some SOPs were missing for tasks such as selling pharmacy medicines over the counter. A pharmacy technician (PT) who had not signed the SOPs confirmed she had read them. 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. But the lack of formal training on SOPs could mean that some members of the team may not always fully understand their roles and responsibilities. Staff did not usually wear uniforms or anything to indicate their roles, so this might not be clear to members of the public. The incorrect RP notice was on display at the start of the inspection, which might cause confusion. This was promptly rectified by the pharmacist on duty, when pointed out.

Members of the pharmacy team explained that when the pharmacist identified an error during the final accuracy check they were asked to rectify the mistake. But team members were not clear about how near miss errors were recorded and reviewed. They could not find the paper record used to record near miss errors, and the electronic software previously used for recording could not be accessed due to the user licence having expired. The trainee pharmacist described an example of a recent picking error involving morphine sulphate and clobazam oral solutions which had been due to similar packaging. This was discussed and highlighted to the rest of the team members to make sure they were extra vigilant when selecting these medicines or putting stock away on the dispensary shelves. Team members were confident that any dispensing errors would be recorded by the pharmacy superintendent (SI), but they were not aware when the last error had occurred, and the records could not be found. The lack of recording and regular reviews could mean the team may be missing out on additional learning opportunities.

The pharmacy supplied a large number of prescription only medicines (POMs) to people living in the UK through its website www.prescriptiondoctor.com. Medicines were supplied against private prescriptions issued by a pharmacist independent prescriber following the completion of an online questionnaire. Prescriptions were received 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 which the team members could check to ensure the prescription was authentic. Prescriptions issued

covered a wide range of medicines including Saxenda injections for weight loss, asthma inhalers, antibiotics for sexually transmitted diseases (STDs) and acne, levothyroxine, propranolol for anxiety, Testogel, HRT, contraceptives, and treatments for erectile dysfunction (ED) and premature ejaculation (PE).

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. 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. There were separate folders of policies and SOPs for the prescribing service. The pharmacy had an identity (ID) checking policy and all people using the prescribing service had their ID checked by a third-party provider. This checked the person's ID by name, address and date of birth. If the person failed the third-party ID check, then the pharmacy asked for further proof of ID such as a passport or driving licence. But the pharmacy did not have a system to verify the ID provided matched the person requesting the medicine, 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. And there was no way of assessing a patient's mental capacity, to determine whether a remote consultation was appropriate.

Prescribing guidance and new medication risk assessments were completed for medicines introduced into the prescribing service. The patient eligibility criteria for Saxenda, was body mass index (BMI) greater than 30 (or 27 with co-morbidities). If the person's BMI was below this, then a clinical assessment should be given. In practice this consisted of obtaining a hip and waist measurement to provide a ratio measuring health risk level. If the ratio was medium or high and other methods of weight loss had been tried, the prescriber could consider a short-term course which would be reviewed to see if the treatment was effective. This would be considered 'off label' use, which means it is outside the terms defined by the licence and so could increase risk. The safeguarding risk of supplying products for weight loss, without physical examination, to vulnerable people with eating disorders had not been considered.

The prescribing guidance and risk assessment for situational anxiety effectively allowed the prescriber to diagnose anxiety and initiate a person on either 10mg or 40 mg propranolol. Anxiety is usually a complex mental health condition, often with several overlapping conditions, which needs psychological and physical assessment by a practitioner before a diagnosis can be made. The consultation questionnaire was the same for initiating treatment (diagnosis) and repeat prescribing and it did not consider the additional assessments of patients required to safely initiate the medication. Propranolol is known to cause severe toxicity when used in overdose. Although it is not known to be an addictive or habit-forming medicine, it may be misused and/or overused by vulnerable people. The risk assessment stated, 'evidence of diagnosis and previous initiation may be requested or SCR checks can be conducted however not necessary.' So the pharmacy had not sufficiently addressed the patient safety risks associated with this medicine.

The risk assessment for asthma stated that diagnosis by a GP or managing physician must have been conducted and annual asthma checks are required. However, although questions were asked about this in the consultation questionnaire, the prescriber generally relied on the information supplied by the person requesting the medicine and the information was not verified against other resources. The risk assessment also stated that the overall care management should be under the patient's GP. But it was not mandatory for the patient to supply their GP's details, and most people did not provide them. This means their own GP might have an inaccurate picture of their inhaler use, and therefore may not be able to appropriately follow up and monitor their condition.

There was a risk assessment which included website and data security. There was an IT security policy with a statement that the user agreed to comply fully with the Company's Data Protection Policy and the General Data Protection Regulation. (GDPR). 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.

Several audits had been carried out by the pharmacy and these included a re-auditing plan depending on the findings. Some of these audits assessed the prescribing process such as reasons for declining orders, adhering to the pharmacy ordering limits and completing follow ups. Others were clinically focused. For example, one audit looked at adherence to national and local guidelines when prescribing antibiotics for urinary tract infection (UTI). These audits highlighted areas where the prescribing service was in compliance with best practice guidance and the pharmacy policy. However, some people with conditions such as asthma, anxiety and weight loss, were potentially not being well-managed, and the audits had not identified these issues.

The pharmacy had a complaints procedure which included recording the issue and referring it to the SI to be followed up. However, there were no details about the procedure on display in the pharmacy, 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 a recognised online customer service review platform to monitor customer service and had a 4.7 out of 5 rating. A current certificate of professional indemnity insurance was seen in the dispensary. The SI confirmed that this covered the pharmacy's internet business. Following the inspection, the SI provided current insurance certificates for the prescriber, which covered his activity as an independent prescriber. However, it did not specify if it covered the prescriber's remote prescribing.

The RP record was available and it was generally in order although occasional entries were missing. Records for controlled drugs (CDs) were maintained electronically and running balances were recorded. A sample of random balances were checked and two inconsistencies were found. The RP confirmed that he would make a record of the discrepancies, so they could be fully investigated. Records for unlicensed specials appeared to be in order. Private prescriptions were recorded electronically. The incorrect prescriber had been recorded on several of the prescriptions from the prescribing service. The previous prescriber, who stopped prescribing for the pharmacy in February 2022 had incorrectly been named as the prescriber on 16 prescriptions the previous day, which might lead to confusion in the event of a problem or query.

Policies relating to data protection in the pharmacy could not be found, and team members do not remember seeing them. This was a risk as some members of the team might not have completed the relevant training. A PT said she had signed a contract which had a confidentiality clause in it when she started working at the pharmacy. She correctly described what confidential information was and explained how it was segregated and removed by a waste carrier. Assembled prescriptions and paperwork containing patient confidential information were stored appropriately so that people's details could not be seen by members of the public. Information about the pharmacy's privacy policy, and how people's information was handled and stored was available on the Prescription doctor website, but there was no information displayed in the pharmacy to inform people about this.

Safeguarding procedures could not be found. And team members do not remember reading procedures about safeguarding or completing safeguarding related training. So, there may be a risk that signs of concern might go unnoticed. A PT said she would report any concerns to the pharmacist on duty. And team members knew where to find the local council's safeguarding number in case of a concern. The pharmacy team were observed using sensitivity and understanding on two occasions during the

inspection when people presented at the pharmacy in a distressed state.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications for the jobs they do. They can provide feedback to their manager about the pharmacy and its services, and they feel reasonably well supported. But team members do not get regular ongoing training, so there may be gaps in their knowledge and skills.

Inspector's evidence

The RP was a locum pharmacist. There were two PTs, a trainee PT, a trainee pharmacist, an MCA, and a delivery driver on duty. One of the PTs was an accuracy checking technician (ACT). The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other. Some members of the team were part-time staff who worked flexible hours. This, along with a temporary reduction in opening hours during the pandemic, had helped ensure adequate staffing levels.

Members of the pharmacy team carrying out the services were experienced and had completed appropriate qualifications. On-going training and protected training time was not routinely provided to members of the pharmacy team. The MCA said she had completed some ongoing training during the previous year, but this was in her own time and was not provided by the pharmacy. Her training records were not at the pharmacy as she had been working on them at home.

A member of the pharmacy team, who had recently started working at the pharmacy felt there was a good level of support from the pharmacists and other members of the team. The SI regularly worked at the pharmacy and a member of the team explained that they would be comfortable talking to the SI about any concerns they might have. They said if there was an issue or a complaint then this would be discussed between members of the team to help share learning and to help prevent a similar event. Other issues were discussed informally within the team.

The pharmacist independent prescriber worked remotely. He had been prescribing for the service for at least nine months and was recruited by the pharmacy when they advertised for new prescribers. He was contracted to work around five hours each day and was paid a set salary. The SI had carried out some due diligence checks on the prescriber which included viewing postgraduate certificates and his registration status before employing him. The SI said the prescriber confirmed that he was confident to prescribe all the medicines offered by the prescribing service and he was particularly competent in prescribing for skin conditions and weight loss. The SI did not know if he had any training in the area of anxiety. The pharmacy had previously worked with an EU doctor, but they had stopped prescribing for the pharmacy in February 2022, and the current prescriber worked in isolation without peer review or clinical leadership.

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

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

Summary findings

The pharmacy generally provides a professional environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to receive services in private and have confidential conversations. The pharmacy's website uses wording that gives people the impression that they can choose a prescription only medicine before having an appropriate consultation with a prescriber, and it could mean they may not always receive the most suitable medicine for their needs. Information about the prescriber's registration is missing 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. Signage in the dispensary requested increased cleaning and disinfection of equipment such as measuring flasks, and members of the pharmacy team said they cleaned the work surfaces more frequently.

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 spacious, and it was seen to be used to provide some services.

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 displayed the name and a photograph of the pharmacist independent prescriber, but it did not include his registration details. And there were misleading references to a 'qualified partner doctor', when a doctor was not currently prescribing for the service. Under each condition on the website the different names of products were shown and their starting price. There was a 'get started' button on each product which gave the impression that the person could choose the specific medicine they wanted to buy, before starting the consultation. This means people may not always receive the most suitable medicines for their needs.

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 suitable for the people it supplies. It supplies some medicines which may not be appropriate to prescribe via a remote consultation based on a questionnaire, because they require physical examination, blood tests or monitoring. And the pharmacy often supplies prescription medicines without informing a person's regular doctor. This means their condition might not be properly monitored or followed up, and their use of medication may not be adequately controlled. The pharmacy offers a range of other traditional 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. But the pharmacy could improve the way it stores and manage some of its medicines.

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 travel vaccinations, but other services were not promoted, so people might not know they were offered. There was a small range of healthcare leaflets and some information on healthy living was on display. Useful information on medical conditions and the medicines available through the prescribing service was available on the website. Healthy living information was sometimes sent to people using the prescribing service. For example, a message was sent to people prescribed Saxenda for weight loss, with links for information on diet and exercise and mental health support.

The pharmacy was partnered with a recognised UK-based clinical laboratory providing screening, monitoring and diagnostic services. The laboratory was UKAS registered and processed the Covid-19s tests supplied by the pharmacy during the pandemic. Test kits for STDs were also available on the website.

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 online consultation questionnaires contained two parts. The first part was standardised for all medicines and the second part of the questionnaire was specific for individual medicines. The pharmacy was able to access patient’s Summary Care Records (SCRs) with the patients’ consent. 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 for any condition. Neither the IT manager nor the customer service manager knew what percentage of people consented to share their information or provided their GP details, and this had not been audited. An example was seen when the pharmacist had viewed a patient’s SCR as part of their clinical check before supplying ramipril, and a pdf copy of their SCR was available on the pharmacy’s computer. An example was seen of a patient who had been prescribed propranolol 40mg for anxiety and had given consent to inform their GP. The IT manager was not able to demonstrate that their GP had been notified. His explanation for this was that the patient had not entered their GP’s name. However, the patient had provided the GP practice details through the Prescription doctor website’s database, so there were sufficient details to ensure the information was shared. There was evidence that some GPs had been notified but a few responses indicated that

some email addresses used were incorrect. This posed a risk as it may mean that GPs do not have full and accurate information about the patients they manage. And people who had consented may believe their GP has been informed when this has not happened.

The consultation questionnaire responses 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 tags included:- 'evidence uploaded,' 'early order', 'LN or EQ (ID) verified', 'review symptoms/therapy before next order'. Some of the medicines that the pharmacy's prescribing service issued prescriptions for were used to treat 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. There were prescribing pathways for medications which formed the algorithm for the questionnaire and fed into the prescribing platform. The prescribing pathways for Saxenda, asthma inhalers, levothyroxine and Testogel indicated that the prescriber should confirm diagnosis or check laboratory results before issuing prescriptions. However, inconsistent practices were seen that were against the pharmacy's own local policies such as issuing prescriptions without confirming the patient's medication history or contacting their GP.

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. Reorder time limits were set for asthma inhalers with a maximum number of two inhalers on each prescription and no more than one inhaler per month. So, if two inhalers were prescribed, then another prescription would not be issued for two months. An example was seen when a patient's repeat request for Ventolin was declined as it had been ordered 'too early' after the previous supply. This suggested that this patient's asthma might be poorly controlled. The patient was sent a message from the prescriber asking, 'when was your last asthma review ?' and 'was there any change in your asthma regimen ?'. The patient had responded that 'everything was still the same'. This patient had not consented to share information with their GP or access their SCRs. A tag 'asthma review' had been added to their record. However, this automated intervention did not provide sufficient reassurance that the patient's asthma was under control. This may be the result of poor adherence to prescribed medication, poor inhaler technique, the presence of other conditions or an incorrect diagnosis, and should be a trigger for a clinical review. The diagnosis and date of last asthma review had not been verified and the patient's GP had not been contacted, which is crucial in managing long-term conditions such as asthma. In an 'early reorder audit' on asthma inhalers it was found that no inhalers had been supplied 'early', but a note of any early orders was not always made on the patient's records to aid in the prescriber's future decision making. Another patient had been prescribed nine salbutamol inhalers in 2020, ten in 2021 and four so far in 2022. This patient had not consented for their own GP to be contacted and information shared with them. So, their own GP was unaware that they had received 23 inhalers from another source, and their GP might be under the impression that the patient's asthma was well controlled. The patient had not consented for their SCRs to be accessed and a diagnosis of asthma had not been confirmed. The use of a high number of salbutamol inhalers such as this is an indicator of poorly controlled asthma. In summary, the pharmacy did not routinely confirm a diagnosis before supplying asthma inhalers or inform the patient's GP, and it did not always adequately monitor or review inhaler use.

People completing the consultation questionnaire for weight loss were required to enter their height and weight, 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. People's GPs were not routinely informed when weight loss medicines were

supplied and the safeguarding risk of supplying them without physical examination, to vulnerable people with eating disorders did not appear to have been considered.

Treatment with Saxenda should be discontinued after 12 weeks if patients have not lost at least 5% of their initial body weight, as per the licensing requirement. The IT manager demonstrated a 12-week assessment tool which had been introduced to help monitor weight loss treatments. Every 12 weeks the system automatically flagged that the patient's weight loss should be assessed. But the flagging system was flawed, and one record checked found a patient had received repeated supplies even though they had not lost a sufficient amount of weight. And subsequent supplies were made to the same patient several months later without effective intervention and monitoring.

Another patient had been prescribed Saxenda four times over the last eight weeks. Their weight had stayed the same during this period of time, and the same height had been entered on the consultation questionnaire, but their BMI, had been miscalculated by the automated system, as it incorrectly indicated it had changed from 26 to 30.5. The prescriber had requested the patient's hip and waist measurements on one occasion and this was on the patient's record. This appeared to be because the patient's BMI was below 30 with no co-morbidity so the hip and waist measurement was to provide a health risk level to justify continuing treatment 'off-label'. A prescribing guidance audit carried out on 52 prescriptions for Saxenda in June 2021 found eight examples when the prescriber had supplied Saxenda to people with a BMIs less than 30 (or 27 with co-morbidities), or when there had been insufficient weight loss to prove effectiveness of treatment, without further assessments such as obtaining their hip and waist measurements to justify their prescribing. The audit's action point was to carry out another audit in twelve months' time. But the pharmacy had not made any other inquiries or changes to make sure prescribing 'off label' was safe and appropriate.

When requesting Testogel, people were required to provide evidence of testosterone levels. Two samples were checked and evidence of low testosterone levels was available on one patient's records, but this could not be verified for the second patient. One patient had consented to access his SCRs, but there was no record showing it had been reviewed. The IT manager said this was because it was the prescriber's decision and he mustn't have felt it was necessary, as the only requirement was evidence of low testosterone levels before prescribing, which he had provided by uploading test results.

People requesting a medication to treat diabetes were asked by the prescriber to provide some form of evidence that confirmed they had been previously prescribed the medicine. This was an extra step, in addition to the consultation questions. An example of this was seen where a patient responded by sending a photograph of some metformin tablets they had previously been prescribed.

Examples were seen of requests which had been refused, either by the prescriber or pharmacist. One example was seen when a request for 14 Macrobid was changed to 6 Macrobid (nitrofurantoin) by the prescriber in keeping with guidelines for uncomplicated cystitis. And in a seven-day audit period 150 requests for medication were declined, eight were refused due to verification or ID failure and 25 orders were cancelled as the medication was deemed unsuitable by the prescriber. The main reason recorded was that the prescriber requested further information/evidence, which the patient did not provide. On one occasion the prescription was refused following the prescriber checking the patient's SCRs.

A follow up email was sent to all people receiving medicine 28 days after their supply asking if they were having any problems or side effects and to confirm the medicine was working. The option of contacting the prescriber directly was available by replying to the email. However, the word 'doctor' was used on the email, and as the current prescriber was a pharmacist, this was misleading. Any reply from the patient was visible on their record. An audit had been carried out of 150 orders and 12

patients responded to the follow up email. Four orders were responded to by the prescriber. Eight orders were not responded to as the prescriber deemed a reply was not necessary. People prescribed Saxenda were sent a link to a video on how to use Saxenda and people were encouraged to get in touch with their GP or the prescriber if they had any adverse effects.

Examples were seen where there were no clear dosage instruction on the medication labels for Salamol inhalers. Labels simply read 'do not take more than 8 puffs in 24 hours , wait at least 4 hours between doses.' Also, propranolol 40mg prescribed for anxiety was labelled 'take one daily as directed by your doctor'. This was confusing as the prescriber was not a doctor, so it was not clear whether the dose was from a previous prescription. The lack of clear dosage information was more of a risk as the consultation was questionnaire based with little or no two-way conversation from the prescriber in relation to dosage. Incorrect dosage labelling had been highlighted on the prescribing audit carried out in June 2021, but the evidence suggested that this issue had not been properly addressed when it was identified.

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, they were packed up in cardboard boxes to protect the medicines. A 'signed for' Royal Mail service was used to deliver the medicines to people, and this could be tracked by the customer service team in the pharmacy. Medicines requiring cold storage, such as Saxenda, were placed in special packs with ice block to ensure their integrity during transit. There was a delivery service for NHS prescriptions. A delivery record was kept of successful deliveries. 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.

Space was adequate in the dispensary, but the workflow was not well organised. The pharmacy was very busy and some of the dispensary shelves were overfull 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, 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. But there were no examples found of dispensed high-risk medicines (such as warfarin, methotrexate and valproate) which had been highlighted to provide counselling. And as NHS prescription tokens were not always retained, members of the team may not always be aware when high-risk medicines or schedule 3 or 4 CDs were being handed out. The MCA described how she would sell a medicine over the counter. She was clear about when to refer to the pharmacist.

A large number of multi-compartment compliance aid packs were assembled in the pharmacy. These included care homes patients as well as 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 surgeries 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 so their carers might not have all the required information to take them medicine safely and effectively.

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 the Prescription doctor prescribing service 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. A PT said she had recently completed date checking within the dispensary. But this had not been recorded, so some stock may be overlooked. A spot check did not find any out-of-date stock on the dispensary shelves. Various tablet bottles were seen on the dispensary shelves, and these were labelled with their contents. But the required details about the date of expiry and batch number were not recorded.

Drug recalls were received by email which all members of the team could access. But there were no records made of the action taken, 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

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. 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.