

# 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:** 20/05/2024

## Pharmacy context

This is a busy pharmacy located on a main road close to the centre of Bolton. It trades extended hours, opening early in the morning and closing late in the evening. 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 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](http://www.prescriptiondoctor.com). It is a pharmacist led prescribing service, so it is not regulated by the Care Quality Commission (CQC).

## 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
<b>1. Governance</b>	Standards not all met	1.1	Standard not met	The pharmacy does not carry out risk assessments for all the medicines it supplies at a distance. This means it cannot always demonstrate that the supplies are made safely. And further proof is not always requested when medicines are sent to alternative addresses which could mean people are supplied with medicines without appropriate identity verification.
		1.2	Standard not met	Members of the team do not consistently record things that go wrong so they can learn from them and so they may miss some opportunities to improve.
		1.7	Standard not met	The pharmacy does not always manage confidential information properly or dispose of it securely. This could result in people's personal information being disclosed.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards not all met	4.3	Standard not met	The pharmacy does not always store its medicines securely and in accordance with legislation.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance Standards not all met

### Summary findings

The pharmacy does not fully manage the risks associated with selling medicines online. It does not gather information about the risks for each individual over-the-counter medicine it supplies and does not assess these risks to help manage them effectively. Some checks of people's identity are completed when ordering medicines online, but there is a risk that these may be ineffective when medicines are delivered to alternative addresses. The pharmacy does not always store or dispose of people's personal information properly. Team members respond appropriately when mistakes happen during the dispensing process, but they do not always make a record when things go wrong so some learning opportunities may be missed. The pharmacy generally reviews and monitors the quality of its services, and it takes some action to improve patient safety. But the pharmacy does not confirm whether people's weights are appropriately verified before weight loss treatments are prescribed. So, it cannot provide an assurance that the medicines it supplies are always suitable. It also does not always review the supplies of medicines for asthma to help make sure they continue to be appropriate. The pharmacy largely keeps most of the records that are needed by law.

### Inspector's evidence

There were standard operating procedures (SOPs) for the pharmacy's services which the superintendent pharmacist (SI) was in the process of reviewing. One team member had started reading through the SOPs as they were being reviewed and updated. The SI provided an assurance that he planned to have the review completed imminently, after which team members would be asked to read through SOPs.

The pharmacy had risk assessments for the clinical conditions it provided prescribing services for. The prescribing policies were underpinned by National Institute for Health and Care Excellence (NICE) and other evidence based clinical guidelines. The risk assessments combined with the pharmacy's prescribing policies reflected clinical risks for each condition. There were clinical justifications for the request of medicines for the conditions based on the history of the presenting symptoms and relevant exclusion criteria based on precautions or red flag symptoms. Risk assessments were seen to have been updated following discussions at the clinical meetings. However, there were no risk assessments available for the sale of pharmacy only and general sale medicines via the pharmacy website. This meant the pharmacy could not demonstrate that the supplies of medicines online are done safely and there was a risk of inappropriate sales being made to people.

The pharmacy supplied a large number of prescriptions only medicines (POMs) through its website to people living in the UK. Medicines were supplied against private prescriptions issued by a team of pharmacist independent prescribers (PIPs) following the completion of an online questionnaire. The pharmacy separated the functions of the prescribing pharmacists from the functions of the responsible pharmacist (RP). The PIPs were based remotely. This helped to make sure that the prescribing pharmacist was not the pharmacist undertaking the final clinical and accuracy checks. Prescriptions were received electronically through a specialised computer system. The prescribers had their own access to the computer system and their IP address was shown on the prescription which the team members checked to help make sure the prescription was authentic. Prescriptions were issued for a wide range of medicines including antibiotics for sexually transmitted diseases (STDs), urinary tract infections (UTIs), skin conditions, injections for weight loss, aciclovir for herpes, hormone replacement

therapy (HRT), contraceptives, treatments for erectile dysfunction (ED), pre-exposure prophylaxis for HIV (PrEP) and asthma inhalers.

All prescriptions generated by the website were dispensed exclusively by the pharmacy. The pharmacy did not routinely dispense prescriptions issued by other online prescribing services. Policies and SOPs for the prescribing service were held electronically. 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 against their name, address, and date of birth. If the person failed the third-party ID check, then the pharmacy usually asked for further proof of ID such as a passport or driving licence. However, online orders could be delivered to an alternative address as requested by the person other than the address on the ID. ID checks were only carried out against the billing address and no further proof of ID was requested in these instances. This meant that there was a risk that the ID check was ineffective and there was a risk that people were supplied with medicines without sufficient verification.

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 addresses, billing addresses, payment method and shipping addresses against their registered address. Any orders which indicated they were from a duplicate account were refused by the team, and the person was contacted to inform them. The order was also recorded in the rejected or refused order list.

The prescribing policy for asthma allowed for the issue of one inhaler every 28 days or two inhalers every 56 days. This meant somebody could receive 12 inhalers in one year, which may indicate their asthma was not well controlled. Salbutamol requests for asthma could not be processed unless a person had documentation on their National Care Record (NCR) which showed an asthma diagnosis and had an asthma review within 12 months. But it wasn't clear if the prescriber was also checking NCR to confirm the person was using a regular preventer inhaler. The risk assessments detailed that the person's clinical record should be checked to make sure suitable inhaler treatment was previously prescribed and also included the steps to take if this was not the case. This also included asking the person to provide evidence issued in the last three months, such as a repeat slip to indicate they had the medicine prescribed by their GP previously. Examples of records were seen where people had provided a copy of their repeat prescription slip and there was also examples seen of the team interacting with people via the messaging service. There were no audits completed to identify the number of inhalers being supplied to people. This meant there was a risk that the pharmacy may not effectively identify people whose asthma was not well controlled and required an review with their doctor.

Prescribing audits were carried out by the clinical lead, who was also one of the prescribing pharmacists. The latest two audits had looked at the prescribing of Daridorexant (Quviviq) for insomnia and rejected /declined orders of Daridorexant (Quviviq) for Insomnia. The audit checked cross referenced prescriptions with NICE and checked if the criteria for prescribing were met for each supply made within a month. Following an analysis of the results, and a discussion at the clinical meeting, a new message template had been added that prescribers used if the person requesting treatment had not met the criteria. Following the audit for rejected prescription orders, prescribers had been requested to check SCR for each request and so that the prescribing criteria was followed. It was unclear if prescribing audits had been carried out on individual prescribers prescribing. So, the prescribers may be losing out on opportunities to improve and develop their skills.

There were QR codes displayed in the pharmacy for recording dispensing mistakes which were identified before a medicine was supplied to people (near misses). Team members explained that near

misses were supposed to be recorded electronically but were not sure that they were consistently recorded. As a result of past near misses, team members said medicines had been moved on the shelves but team members could not recall examples of medicines that had been separated. The SI reviewed near misses, but this was not discussed with the team and no records were made of the reviews. So, team members may lose the chance to learn from past incidents. Any changes which were implemented were shared with the team via an electronic messaging application. The team explained that dispensing mistakes which had happened, and the medicine had been supplied (dispensing errors) were brought to the attention to the RP. The SI was notified of all dispensing errors, and he would investigate and make a record of the incident electronically. Completed records could not be located but copies of incident reports which had been completed as part of the online pharmacy service were subsequently provided.

A correct RP notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. Prescribers also had their own independent insurance arrangements. A complaints procedure was in place and an electronic tablet was kept at the front of the store to gather feedback. The Prescription Doctor website gave the contact details of customer service and there was a form to report complaints on. The pharmacy used a recognised online review platform to monitor customer service.

The RP record was available, and it was generally in order although a couple of entries were missing. So, it may make it harder to identify who was responsible at that time. Records for controlled drugs (CDs) were maintained electronically and running balances were recorded. A sample of random balances were checked and found to be correct. Records for unlicensed specials appeared to be in order. Private prescriptions were recorded electronically. The pharmacy kept a record of all patient consultations and interventions on its own internal systems. They recorded if NCRs had been accessed. It kept records for the refusal of medication requests and communication with a person's GP. The pharmacy also kept a record of all the private prescriptions they supplied. Digital copies of private prescriptions could be easily retrieved.

When questioned, team members explained they separated confidential information into confidential waste bags. But these were stored in the consultation room and were unsealed. And the room was unlocked which made it accessible to people using the pharmacy. The consultation room also contained baskets of assembled prescriptions with confidential information which were waiting to be checked. The dispensary could be accessed via from the retail area of the shop. and people using the pharmacy were able to see confidential information. The SI could not provide any information governance policies to help show how they protected people's information. A piece of confidential information was also found in a bin bag containing general waste. This meant the pharmacy was not adequately protecting people's information from unauthorised access. Information about the pharmacy's privacy policy, and how people's information was handled and stored was available on the Prescription doctor website.

Members of the team explained they would raise safeguarding concerns with the pharmacist if they had any suspicions. But there were no safeguarding procedures available. The pharmacist had completed level two safeguarding training. But other members of the team had not. And the contact details for the local safeguarding board were not immediately available. So, members of the team may not always be aware about how to raise a concern in a timely manner.

## 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 pharmacy team included the RP who was also the SI, a trainee pharmacy technician, a trained dispenser and a medicines counter assistant who was completing their probation. Other team members who were not present included another trained dispenser. The RP said two team members were completing the accuracy checking course. All members of the pharmacy team were appropriately trained or on accredited training programmes.

During the inspection, it was seen the RP was often busy with appointments booked for services provided and there was a large number of prescriptions waiting to be checked. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the team completed pharmacy qualification training suitable for their roles. But further learning was not provided. A dispenser said they would sometimes read training material received from wholesalers but this activity was not documented to show when it was completed. And there was no formal appraisal programme. So, learning and development needs may not always be fully addressed.

A new member of staff had recently started to work on the medicines counter. When questioned, they provided examples about how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. They felt well supported and able to ask for help if they felt they needed it.

Members of the team were seen working well with one another, assisting with any queries they had. They discussed their work to keep up to date when they had been absent. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no professional based targets in place.

The pharmacy had three PIPs who provided the prescribing service. One of the PIPs was the clinical lead. Training completed by all the prescribers was collated by the clinical lead. Clinical meetings were held which were attended by the prescribers, SI and IT manager.

The pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing requests for medication via the online prescribing service, where requests were not appropriate. The pharmacy had records of a large number of refusals for people who had ordered medicines via the website too many times, or had ordered medication too early, or had expressed symptoms that would exclude them from treatment or had a medical condition on their SCR that would contraindicate them from treatment.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy generally provides a suitable 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 have confidential conversations. However, patient sensitive information is not always stored securely in the consultation room. The pharmacy's website provides information about the pharmacy and the prescribing service so that people can understand the services that are available.

### Inspector's evidence

The pharmacy premises including the shop front and fascia 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.

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. However, the room was used to store confidential waste and baskets containing assembled prescriptions which were waiting to be checked. The dispensary could be accessed via from the retail area of the shop. People using the pharmacy were able to see confidential information and some prescription only medicines including some assembled prescriptions were within easy reach.

The pharmacy website's layout was compliant with GPhC regulation. People were required to complete a consultation before a medication could be selected. And the consultation questionnaire did not indicate if an input would prevent a medication being issued. The name and physical address of the pharmacy was displayed on the website and the registration number of the pharmacy and SI. The website displayed the name and registration number of the PIPs.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy offers a wide range of healthcare services, which are generally well managed and easy for people to access. The pharmacy obtains its medicines from licensed sources but does not always keep its medicines secure from unauthorised access. The pharmacy team has professional oversight of all online medicine orders and systems are in place to intervene when there are clinical issues with prescriptions. However, the pharmacy does not always carry out checks to help make sure the medicines it prescribes are appropriate for people so it cannot always demonstrate that the supply is safe.

### Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. 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 offered by the prescribing service was available on the website. Team members were multilingual and spoke a range of languages that were spoken locally.

People requesting prescription medicines from the prescribing service were asked a series of questions. Their responses were sent to the prescriber for approval before a prescription was generated and a supply was made. The online consultation questionnaires contained two parts. The first part was standardised for all conditions and the second part of the questionnaire was specific for individual medicines. The consultation questionnaire responses could be viewed by both the pharmacy and the prescriber and key questions were highlighted in red. Patient consent to access to SCRs was requested in most of the questionnaires, and providing consent was mandatory for conditions such as asthma, weight loss, insomnia and gout. Several examples were seen when the pharmacist or prescriber had viewed a patient's SCR before prescribing or supplying a medicine and an electronic copy of their SCR was available on the pharmacy's computer. Consent to share information with their GP was requested in most of the questionnaires and it was mandatory for conditions such as asthma and weight loss. People could enter their GP practice details using the website's database. If an email address wasn't available on the database, a letter would be printed off and posted to the GP practice to ensure the information was shared. Evidence of both emails and letters to people's GPs was seen. People 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 the patient's records building up a profile of the person. Tags included:- 'ID verified', 'await results,' 'evidence uploaded' and 'review symptoms/therapy before next order.'

There were ordering limits for certain medicines built into the prescribing portal which were programmed to alert when orders were placed too soon. 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 which could be ordered over two months. However, this could result in someone obtaining 12 inhalers in a year which was not in line with guidance and could indicate that someone's asthma was not well controlled. Data showing the number of salbutamol inhaler supplies made was seen and showed that there had been instances where people had been supplied with six to



nine inhalers within a period of a year. There was no evidence seen of any audits completed for asthma treatments that had been supplied so the pharmacy could not demonstrate that they had effectively monitored the supply of these inhalers to identify any inappropriate prescribing.

People completing the consultation questionnaire for weight loss treatments entered their height and weight, and the pharmacy took steps to verify that this information was correct. This could be done by uploading a letter from a health specialist confirming the person's weight, a video/image of the person showing their body profile or evidence from their SCRs. People were also allowed to upload a photograph showing the scales alongside their photographic ID. However, there was nothing to show that the person on the scales was the person requesting the medication, as only their feet could be seen. The IT manager reported that the system recorded when a file was captured and uploaded.

Prescribers often issued prescriptions for Duraphat toothpaste, a prescription only strength of sodium fluoride toothpaste. This product was usually prescribed by dental professionals and it was unclear if the PIPs had completed adequate training to prescribe this treatment which meant supplies may not always be appropriate.

Following an audit on treatments prescribed for sexually transmitted infections, the policy for requesting test results had been amended and this was no longer required. However, this was not in line with the risk assessments seen for chlamydia which stated that a positive test was a prerequisite for obtaining treatment. There was an increased risk of people receiving inappropriate treatment in the absence of confirmed positive tests. The clinical lead provided an assurance that she would review this.

Orders received for pharmacy only and general sale medicines were processed in the main pharmacy. The questionnaires were printed off and assessed by the RP and then processed.

Prescriptions were dispensed by the dispenser and checked by the RP. 'Dispensed-by' and 'checked-by' boxes were available on the dispensing labels. These were initialled by team members to help maintain an audit trail. The pharmacy team used baskets for prescriptions to help make sure people's prescriptions were separated and to help reduce the risk of mistakes. The pharmacy had an allocated team member who managed repeat prescriptions. The team member called and checked with people what medication they required before sending the request to the doctor surgery. Once prescriptions were received back, they were checked to ensure all the items requested on the prescription were received and any missing items were followed up with the surgery. Private prescriptions were downloaded and dispensed by the team. Team members explained that any issues such as frequent ordering was flagged with the RP who would then contact the customer services team.

Team members were aware that sodium valproate was to be dispensed in its original container, however, they were unsure if anyone had sodium valproate supplied within the multi-compartment compliance packs and provided an assurance that they would check. Additional checks were only carried out when people who were supplied with medicines which required ongoing monitoring collected their medicines from the pharmacy. Checks were not carried out with people who had their medicines delivered which meant some people may not get the additional advice needed to help make sure they are taking the medicine safely. The RP provided assurance that he would look into how this was done.

In advance of providing the Pharmacy First service the RP had attended face to face training. However, there were no signed PGDs available. Following the inspection, the SI confirmed these had been signed.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. Prescriptions received from the surgery were checked for any changes or missing items before being handed to the dispensers to prepare. Once prepared the packs were checked by the RP and then sealed. A number of prepared packs were seen in the consultation room, all of which were unsealed. Some of these were waiting to be checked and others had items missing which had been ordered or there were queries with the prescriptions. Team members agreed that there were risks in storing medicines in this way and provided an assurance that this would be reviewed. The pharmacy also supplied medicines to people living in care homes. Some of the care homes ordered repeat prescriptions directly from the surgery which were sent to the pharmacy and other supplied the pharmacy with reorder forms which were processed, and prescriptions ordered by the pharmacy team. Prescriptions for acute prescriptions were received electronically. These were dispensed and supplied on the same day where possible. Medication administration records (MAR) charts were sent with all dispensed medicines including those required on an acute basis. Packs which were ready to collect were labelled with product descriptions and mandatory warnings. Patient information leaflets were supplied on a monthly basis.

Deliveries were completed by one of two designated drivers. An electronic system was used to book in deliveries which created an audit trail. People signed when their medicines were delivered. In the event that someone was not home, the medicines were returned to the pharmacy. Medicines sent out as part of the prescribing service were sent using a third party tracked service. Deliveries were attempted three times before they were returned back to the pharmacy. For medicines which required cold chain the pharmacy had used a Bluetooth module in a test parcel to monitor the temperature throughout the course of the delivery period to help make sure the correct temperature was maintained.

There were two medical fridges. Both fridges had a built-in thermometer which was seen to be within 2-8 degrees Celsius. Records indicated the minimum and maximum temperatures were being monitored regularly for both fridges. Licensed wholesalers were used for the supply of medicines. However, assembled prescriptions were not always stored in areas which could not be accessed by people using the pharmacy. Date checking was completed by the team. But records were not kept showing when date checking had been completed. So, some areas of the dispensary might be overlooked. Some date expired medicines were seen on the shelves checked. Drug recalls were received electronically. Team members marked on the system when the recall had been actioned.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

Members of the pharmacy team have access to 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

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.

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.

### 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.