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: 05/12/2024

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 pharmacist-led prescribing service which people can access from its website www.prescriptiondoctor.com.

Overall inspection outcome

✔ **Standards 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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy's working practices are suitably effective. The pharmacy manages its NHS services reasonably safely and it keeps the records required by law. Team members make records of dispensing mistakes and take action to learn from them to make services safer. The pharmacy has risk assessments and policies for its online prescribing services, but these sometimes lack clarity, which means team members might not always work effectively. And the pharmacy could improve the quality of its audits, so it can demonstrate how it makes sure its online prescribing services are safe.

Inspector's evidence

There were standard operating procedures (SOPs) for the pharmacy's services which the superintendent pharmacist (SI) had reviewed since the last inspection. Not all of the team members had read the SOPs relevant to their roles which meant they may not fully understand the correct way to complete the tasks they were allocated. The responsible pharmacist (RP) provided an assurance that he would ensure team members completed this promptly.

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). This helped to make sure that the prescribing pharmacist was not the pharmacist undertaking the final clinical and accuracy checks. The PIPs were based remotely. Prescriptions were received electronically through a specialised computer system. The prescribers had their own access to the 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. Since the last inspection the pharmacy had also introduced an additional 3D factor verification check to further verify the person's identity.

There was an order processing guide which outlined how the team processed the online 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 of this. The order was also recorded in the rejected or refused order list.

The pharmacy provided updated risk assessments for the health conditions it provided prescribing services for. The prescribing policies were underpinned by NICE and or other evidence based clinical guidelines. The pharmacy had policies and procedures in place which safeguarded against people submitting early orders. The risk assessments combined with the pharmacy's prescribing policies reflected the identified clinical risks for each condition. There were clinical justifications for the request of medicines for the conditions based on the history of the presentation and relevant exclusion criteria based on precaution or red flag symptoms. Consent to access National Care Records (NCR) was mandated for certain higher risk conditions such as asthma and weight loss. But this was not the case for conditions where treatment with an antimicrobial could be commenced. Since the last inspection a risk assessment had been completed for over the counter (OTC) medicines which were sold. There was supporting documentation alongside this which listed the maximum quantity of a medicine that could be purchased as well as any ongoing monitoring that was required. However, the age range for treatment depending on the license of that medication was not specified clearly on either of the documents. This would be useful so that the pharmacy can demonstrate how they manage age restricted sales and would help to provide further guidance for its team members. The team member explained that all requests for OTC medicines were checked by the RP who was also able to see previous buying history and consent to check NCR was requested for some medicines. The team member provided an assurance that he would raise this with the SI and clinical lead.

The written policy for weight loss medication requested video or photo evidence of a person to determine body shape before considering if a supply could be made. NCR was accessed to ensure the patient did not have any medical exclusions.

The pharmacy had completed two clinical audits since the previous inspection. One audit was for a condition where there were low levels of requests and the other was for the pharmacy's weight loss service but only involved one medication. However, the evidence provided for the weight loss service audit was insufficient for the level of prescribing which meant it may not provide the pharmacy with enough information about how safe and effective the service is. The risks of this were discussed with the RP.

There were QR codes displayed in the pharmacy for recording dispensing mistakes which were identified before a medicine was supplied to people (near misses). Since the last inspection it was seen that more near misses were being recorded. As a result of past near misses, team members explained how some medicines had been moved on the shelves such as omeprazole capsules and tablets. Near misses were reviewed and discussed with the team as they occurred. Any changes to be implemented were shared with the team members present and via an electronic messaging application. The SI reviewed near misses and discussed it with the team. But no records of the reviews were maintained which would be useful so that the pharmacy was able to demonstrate the action it took following the review. 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.

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.

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 in order. 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. Private prescriptions were recorded electronically. The pharmacy kept a record of all patient consultations and interventions on its own internal systems. They recorded if the NCR had been accessed. It kept records for the refusal of medication requests and communication with a person's regular 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. The dispensary could be accessed via from the retail area of the shop and people using the pharmacy were able to see some confidential information. This was rectified by the RP during the inspection. Team members had been briefed on confidentiality and data protection.

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 three safeguarding training. Other members of the team had completed training on the eLearning for health (Elfh) website.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. Team members are given some ongoing training. But this is not structured which could make it harder for them to keep their knowledge and skills up to date. They can provide feedback to their manager about the pharmacy and its services, and they feel reasonably well supported.

Inspector's evidence

The pharmacy team included the RP, a trainee pharmacy technician, a trained dispenser, three trainee pharmacists and a counter assistant. Team members felt that there were enough staff to cover the workload, and the team were up to date.

Most members of the team had completed pharmacy qualification training suitable for their roles. But there was no formal structure for further learning. A dispenser explained they would sometimes read training material received from wholesalers, but this activity was not documented to show when it was completed. Information on new products was shared with the team which included any training material provided by the manufacturers. The team had recently completed training for tranexamic acid. Pharmacists briefed the team on any new services that were introduced. There was no formal appraisal programme. Team members were provided with ongoing feedback by the pharmacists and had a one-to-one conversation with the directors at least annually. Team members felt that they were able to provide feedback and suggestions, and the text messaging service was introduced after the RP suggested it to the directors.

A member of staff provided examples about how they sold pharmacy only medicine using the WWHAM questioning technique and referred to the pharmacist before selling any medicines. 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.

Trainee pharmacists felt well supported by the team and the pharmacists. They had been signed up to a training provider and were provided with their study time as well as time to complete the online training.

The pharmacy had three active Pharmacist Independent Prescribers (PIPS) who shared the workload. The pharmacy did not a have a complete record of the required training certificates and testimonials for all of it is PIPs. For example, the pharmacy did not have the relevant certificates for the safe prescribing of antimicrobials, oral contraceptives, medication for menopause and weight loss medication for some of its prescribers. So, this could mean that the pharmacy may not have complete assurances that prescribers were working within their competence. It was not clear if the PIPs had access to medical peers who they could contact for support. The pharmacy conducted multi-disciplinary team meetings which consisted mainly of the PIPs and the customer contact team.

The pharmacists who provided cover in the pharmacy were empowered to exercise their professional

judgement. 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 NCR that would contraindicate them from treatment. The PIPs were not incentivised to prescribe.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy 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. 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 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. 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 dispensary could be accessed via the retail area of the shop. The pharmacy website's layout was compliant with GPhC regulation. 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 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 and generally manages them appropriately so that they are safe for people to use. 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.

Inspector's evidence

The pharmacy, consultation room and retail area 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.

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 people and checked 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. Additional checks were only carried out when people who were supplied with medicines which required ongoing monitoring, for people who had their medicines delivered any checks were carried out at the point of ordering prescriptions.

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 small number of prepared packs were seen on the shelves, all of which were unsealed. Some of these had been dispensed the day before and were waiting to be checked. And others had items missing which had been ordered from the wholesalers. The lids of the packs were closed by the dispenser when brought to their attention. 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 doctor 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.

The pharmacy used specialist cold chain packaging which included the use of refrigerated cool packs and had access to data provided by the manufacturers on maintenance of the cold chain in different ambient temperatures. 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. The pharmacy used two different postage companies who provided national coverage. All post were tracked, and the pharmacy had appropriate systems in place for failed deliveries.

There were three medical fridges. Records for two fridges indicated the minimum and maximum temperatures were being monitored regularly and were seen to be within the required range for the correct storage of medicines. The third fridge was on the first floor. The temperature for this had not consistently been recorded since the beginning of November 2024. At the time of the inspection, the temperature of the fridge was within the required range. The RP provided an assurance that the fridge temperature would be checked and recorded daily. Licensed wholesalers were used for the supply of medicines. Date checking was completed by the team. Date checking records were kept and were up to date. No 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

The pharmacy has the appropriate range of equipment and facilities it needs to provide its services adequately.

Inspector's evidence

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were used for liquid CDs. 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. Electrical equipment appeared to be in good working order. Blood pressure monitors including an ambulatory monitor, an otoscope and thermometer were available and used for some of the services provided; the RP said these were calibrated annually.

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.