General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy First, Unit 5, Crown Point South Industrial Park, King Street Denton, MANCHESTER, Lancashire, M34 6PF

Pharmacy reference: 1107410

Type of pharmacy: Internet / distance selling

Date of inspection: 15/06/2021

Pharmacy context

This is a pharmacy which offers its services to people through its website (www.pharmacyfirst.co.uk). People do not visit the pharmacy in person. The pharmacy mainly sells toiletries and over-the-counter (OTC) medicines, but it also has a prescribing service provided by a doctor based in the Czech Republic. A wide range of prescription and OTC medicines are available via the website. The website is also linked to another prescribing service (PhamaDoctor) which uses a UK based prescriber, and the pharmacy supplies a small number of prescription medicines through this service. The pharmacy dispenses a very small number of NHS prescriptions and occasional veterinary prescriptions. 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 does not effectively identify and mitigate the risks associated with the services it provides. The pharmacy's risk assessments are inadequate.
		1.2	Standard not met	The pharmacy does not have adequate prescribing policies and it does not effectively audit or review the prescribing service to make sure it is safe and in line with UK national guidance.
		1.6	Standard not met	The pharmacy's responsible pharmacist (RP) record and private prescription records are not accurate. Prescribing records are not available.
		1.8	Standard not met	People are able to obtain prescription medicines including contraceptives, and high risk pharmacy medicines, without providing proof of their name, address or their age, which is a safeguarding concern.
2. Staff	Standards not all met	2.2	Standard not met	Several members of the pharmacy team do not have the appropriate skills, qualifications and competence for their role and the tasks they carry out. And there is a lack of clinical supervision.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website uses unprofessional terminology and incentivises the purchase of medicines. And the third-party's prescribing service allows a person to select prescription only medicines before starting a consultation with a prescriber.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy is not able to demonstrate that safeguards are in place to make sure the medicines it supplies are clinically appropriate. This includes:- verifying the information provided by the person completing the online questionnaire, confirming a diagnosis, sharing all relevant information about the prescription with the patient's regular doctor and ensuring effective monitoring is in place. And the online questionnaire is set up so that it is clear which answers will prevent the supply of a medicine, so people may circumvent

Principle	Principle finding	Exception standard reference	Notable practice	Why
				this in order to receive the medicine they want.
		4.3	Standard not met	The pharmacy cannot provide assurance that the medicines it supplies are always fit for purpose. Medicines which have been returned to the pharmacy following failed deliveries are put back into stock to be used again. And medicines requiring refrigeration are not always stored at the correct temperature prior to supply.
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 identify and manage all of the risks involved with its services, particularly in relation to its prescribing services. This means that there are some risks to patient safety. People might be able to obtain medicines that are not suitable or could cause them harm. And people can purchase some medicines without providing proof of their name, address or their age, which is a safeguarding concern. Team members have not confirmed their understanding of the pharmacy's written procedures, so they may not always follow them, or fully understand their roles and responsibilities. The pharmacy works with a prescriber based in Europe, so they are not registered or monitored by a UK healthcare regulator. And the pharmacy does not effectively audit or review the prescribing service to make sure it is safe and that prescribing is in line with UK national guidance. The pharmacy's records are not accurate, which could make it harder to understand what has happened if problems occur.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided, but these did not indicate which members of the pharmacy team had read and accepted them, so some members of the team might not fully understand the pharmacy's procedures. The business development manager explained that some of the SOPs were being reviewed and confirmed she would ensure all the team read them once they had been finalised. There were various different roles in the pharmacy team including dispensary, warehouse, accounts, IT and customer service staff. Members of the team appeared to be clear about their roles and responsibilities, but they were not clearly documented, and were not always in line with their training and experience. Team members were not wearing uniforms or anything to indicate their role. The name of the responsible pharmacist (RP) was not prominently displayed in the pharmacy, so it might not be clear to members of the team who was the RP at any particular time. The name of the RP on duty that day was advertised on the pharmacy's website, but it was incorrectly showing as the name of the pharmacist superintendent (SI), which was misleading and could be confusing if there was a problem or query.

A range of prescription only medicines (POMs) were offered via the website. People could request a prescription by filling in an online questionnaire which was then assessed by the doctor before the pharmacy supplied the medicine. These included treatments for acid reflux, acne, asthma, bacterial vaginosis (BV), chlamydia, cystitis, erectile dysfunction (ED), hayfever, emergency hormone contraception (EHC), weight loss, skin conditions, thrush and traveller's diarrhoea. There was a risk assessment for some of the POMs that the pharmacy supplied, but a risk assessment had not been completed when Saxenda was introduced to the prescribing service. The risk assessments were said to have been developed using the British National Formulary (BNF) and National Institute for Health and Care Excellence (NICE) guidelines, but they didn't specify which NICE guideline. The risk assessments had been written by the warehouse manager, who did not have any pharmacy related training or qualifications. There was no consideration of requesting consent to contact a patient's GP built into the risk assessments, or that the customer may not provide correct and complete information. There was a safeguarding risk of supplying products for weight loss, without physical examination, to vulnerable people with eating disorders. And there was no way of assessing a patient's mental capacity, to determine whether a remote consultation or use of online questionnaires was appropriate. There were

no identity checks for the prescribing service so the prescriber and pharmacy had no way to satisfy themselves that the person was genuine and who they claimed to be. The consultation required the patient to confirm that they were over 18, however no proof of their age was requested. The only assurance of age was that the person was required to use a credit or debit card for the prescribing service, but this didn't prevent a child using their parents payment card.

The control measures detailed in the risk assessments to mitigate risks were not always followed in practice. For example, the asthma risk assessment stated, 'as asthma is a condition that required ongoing management we would speak to their GP or regular prescriber to check the order and subsequent prescription were suitable and safe'. There was no record of this happening when asthma inhalers were supplied. The risk assessment for asthma stated that only two inhalers should be prescribed per month. However, evidence of larger or more frequent supplies was seen. There were a number of occasions where four inhalers had been supplied at once, and several instances when patients had received supplies of inhalers too frequently without any clear justification, which should raise concerns as to whether a person's asthma was controlled, and should result in the person being referred to their primary care provider for review.

There was an 'antimicrobial medication form', which stipulated the RP should check that a patient had not recently ordered antibiotics. There were several occasions where patients had received more than one supply of metronidazole within six months for BV without being referred to their GP or sexual health services. Recurrence of BV is common, however the NHS page for BV recommends that patients may require longer treatment if they have had more than two occurrences in 6 months, and therefore the patient may require a referral to their GP or sexual health clinic. NICE and British Association for Sexual Health and HIV (BASHH) guidance recommend that for recurrence diagnosis should be reconsidered and contributing factors to BV should be enquired about. However, there was no evidence of this, or of any referral, which illustrates that prescribing was not in line with best practice guidance. The RP stated that she added alerts if she was unhappy with the supplies and would speak to the pharmacy manager. She believed the order would then be cancelled, and that the pharmacy manager would speak to the patient, however she wasn't sure this actually happened. And alerts on PMRs were not consistently entered. There was no opportunity for patients to directly speak to the pharmacist or the prescriber. There was a 'medicine requiring ongoing monitoring form' but this was not being used. There were no prescribing policies, prescribing reviews or clinical audits available at the inspection, so the pharmacy could not provide assurance that the prescribing was in line with UK national guidance. And there were no prescribing records or records of prescribing decisions or instances where the prescriber refused a supply. Following the inspection, the SI provided additional information which included a policy for asthma and an audit of 30 prescriptions across a three-month period. The asthma policy was inadequate and vague. It did not state who had written it or what reference sources were used. It stated they would only prescribe for acute asthma, but it didn't define this. The policy was not being followed in practice as it stated people ordering salbutamol inhalers on a regular basis were required to provide consent for the pharmacy to view their Summary Care Record (SCR), which had not happened on any occasion. The audit was of poor quality. The methodology was unclear and there were no specifics on which NICE guidelines were being followed or how the prescriptions had been selected. It was completed by a non-clinician, who was not appropriately qualified to assess prescriptions against guidelines.

There was a SOP for OTC sales of analgesics containing codeine and dihydrocodeine. This had been prepared by the warehouse manager. A risk assessment for pharmacy (P) and general sale list (GSL) medicines was available. Risks were identified around inappropriate sales and quantities of medicines and some maximum limits had been added to the website to prevent customers over ordering. And high-risk medication such as laxatives, sedatives and pain medication went through additional checks.

There weren't any risk assessments for individual medicines but there were procedural sheets for each of these categories, which outlined the checks, restrictions and the action to take. The identity of the person requesting a P medicine was not verified, which may be a safeguarding risk for some medicines and under-age people could obtain medicines. The pharmacy had decided to stop selling codeine linctus and Phenergan elixir because of the risk of abuse; however, Phenergan tablets were still supplied and codeine linctus was still advertised on the pharmacy's website and could be added to a person's 'wish list'. The pharmacy manager explained that codeine linctus was still on the website as it had a positive effect on the rating of the website but he would remove it from the website if this was required.

The business development manager confirmed there had been a full team discussion about coronavirus and individual staff risk assessments had been completed. Team members did not routinely wear face masks and the business development manager explained this was because they treated the team as one 'bubble', however this increased the risk of infection transmission. Team members carried out regular lateral flow tests and had been vaccinated. The body temperature of visitors to the pharmacy was checked on arrival, using a forehead scanning device. A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services.

There were SOPs for dealing with dispensing incidents and near miss errors. Incident reporting forms and near miss logs were available but weren't being routinely used, so the team might be missing out on learning opportunities. The RP explained dispensing errors were rare because the volume dispensed was relatively low. She pointed out a 'check strength' sticker in front of tadalafil which the pharmacy used to prevent a picking error with this medicine.

There was a customer service section on the website with a 'contact us' tab. A customer satisfaction survey had taken place in January 2019, in relation to the NHS prescription service and the results were available on the website. The pharmacy used Trustpilot to monitor customer service of its online services and it had a 4.7 out of 5 rating. A current certificate of professional indemnity insurance was on display in the pharmacy. The manager believed this covered all the activities carried out at the pharmacy, and that the insurance provider was aware of the use of a non UK-based prescriber. He agreed to contact the provider and confirm this. The pharmacy manager was not able to locate the prescriber's indemnity arrangements however following the inspection he provided some documentation. It was not written in English but the pharmacy manager stated that they had translated the insurance document and were fully satisfied with it.

Private prescriptions were recorded electronically, but some information had not been entered correctly which compromised the accuracy of the records. For example, some private prescriptions from the prescribing service had been incorrectly recorded as NHS FP10 prescriptions. There were several veterinary prescriptions which had been supplied from copies of the prescriptions, which had been sent by email, but the pharmacy had not obtained the original prescription. There was an electronic RP log. The RP had not recorded the time she had commenced her duties on the day of the inspection. She added the time retrospectively, but the failure to contemporaneously complete the RP log compromised its accuracy. The pharmacy manager stated that the pharmacy operated from 8am to 5.30pm Monday to Friday and had an NHS contract (40 hours). However, there was no RP recorded on nine weekdays between 5 May and 14 June 2021. On some days the RP log indicated that the RP was only present for two or three hours, and no absences had been recorded. On days when the SI was RP there was no record of the time he had ceased his duties. This meant the pharmacy could not reliably demonstrate when a pharmacist was present, as required in the RP regulations and the pharmacy was effectively operating without an RP on some days. And the team carried out activities requiring an RP, when no RP was signed in. The business development manager said there was always a pharmacist on the premises when the pharmacy was operating, however sometimes the directors would go straight to

their office without signing in as RP.

Confidential waste was placed in designated bins which were collected by a waste disposal company for shredding. A member of the team understood the difference between confidential and general waste. A privacy policy was available on the website, along with the details of the pharmacy's data protection officer (DPO) and registration details with the Information Commissioners Office (ICO). The pharmacy had a safeguarding policy. The SI, RP and business development manager had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. The team knew where to report concerns but did not believe they had come across anything they considered to be a safeguarding concern.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to manage its workload, but some members of the team are doing tasks that they aren't trained or qualified to do, which increases the chances of mistakes happening. The team members work well together, and they are comfortable providing feedback to their manager. But these communications are not always recorded, and the pharmacy does not always respond appropriately when team members raise issues.

Inspector's evidence

There was a pharmacy manager, an RP, a business development manager, a warehouse manager, two warehouse operatives, two account staff, a customer service assistant and an IT and online marketing assistant on duty at the time of the inspection. The staffing level was adequate for the volume of work. The pharmacy manager ensured that the staffing levels matched the workload and some members of the team were part-time and were asked to work extra hours when required. The pharmacy manager had a background in IT and dealt with any website issues. The business development manager had previous experience in an online pharmacy and was a pharmacy technician (PT). The warehouse operatives were completing warehousing apprenticeships. One of the warehouse operatives was on an accredited dispensing assistant training course, but the other operative was not enrolled on a pharmacy training course even though he was involved in the selection and packing of P medicines. The RP was a regular pharmacist who worked three days every week. There were two directors who were both pharmacists. One of the directors was the SI, and he usually worked as RP at least two days each week. Neither of the directors were present at the inspection. The customer service assistant had not completed any pharmacy training. She was aware she was not competent to give advice about medicinal products and said she would signpost people to their GP or their local pharmacy, if she thought this was necessary.

Team members were given formal appraisals where performance and development were discussed with their line manager. Informal meetings were held within the various teams and there were occasional all staff meetings, such as one on Covid-19. Not all of these meetings were documented so there was a risk that some concerns were not recorded, and so they might not be addressed. Team members confirmed they would feel comfortable talking to the RP, SI or the other director about any concerns they might have. Members of the pharmacy team said they had voiced concerns to the SI about the supply of some medicines via the internet but had been told not to worry. There was a whistleblowing policy.

There was a role described as Clinical Governance lead (CGL) in the pharmacy's procedures. The RP did not know who this was and was not aware of any clinical audits having taken place, which was one of the listed responsibilities of the CGL. The pharmacist checked P medicines and prescriptions before they were supplied and was able to exercise their professional judgement in deciding if to supply or not. However, the pharmacist did not always have access to the patient's history for P meds. This means they did not have all the relevant information they may need to ensure a supply was safe for the patient. The RP did not usually communicate directly with patients and communication was through the customer service team. She said she would welcome the option of viewing a person's SCR in order to

establish that they were asthmatic, before supplying Ventolin for example. She had suggested this to the pharmacy manager or SI but it had not been taken forward. The pharmacy manager confirmed the only targets were customer service related, and they did not relate directly to sales or prescription items.

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

Summary findings

The premises generally provide a professional environment for people to receive healthcare. But the pharmacy's website inappropriately incentivises the use of medicines and the third-party prescribing service allows people to select the prescription only medicines they want before they have a consultation with a prescriber. This is not appropriate as it means people may not receive the most suitable treatment option for their needs. Information about the prescriber is difficult to find on the pharmacy's website and so people may not have enough information to make an informed decision about their care.

Inspector's evidence

The pharmacy premises were reasonably clean and in an adequate state of repair. The temperature and lighting were suitably controlled on the ground floor, where the pharmacy was located. The premises consisted of a large warehouse where P and GSL medicines were stored, picked, and packed ready for postage. There was a separate dispensary where POMs were stored and dispensed. This room had a lock on the door which could restrict access when the pharmacy was closed. Staff facilities included offices, a small kitchen area and two WCs with wash hand basins and antibacterial hand wash. There was hot and cold running water.

Some of the online consultation contained wording about Simple Online Pharmacy, which is a different pharmacy and may be confusing to people using the website. Some terminology on the website for the prescribing service was very transactional such as ‘top sellers’, ‘shop now’ and 'add to bag’ which detracted from the professional image of the website. People were also incentivised to ‘bulk buy’ P medicines with ‘deal of the week’ and discounts for both P and POMs, which was unprofessional and could encourage inappropriate use of medicines.

Some parts of the pharmacy’s website were correctly arranged so that people completed a consultation questionnaire before selecting a POM, such as for the treatment of acid reflux. However, for some treatments such as ED and weight loss, the person chose their preferred option before commencing the consultation. The pharmacy manager agreed to change the layout so everything was arranged in the same way as for the acid reflux treatments. These changes were made immediately following the inspection. The third-party prescribing service (PharmaDoctor) allowed the selection of a medicine before the consultation, which was not in line with GPhC guidance and might result in the person receiving a medicine which was not the most appropriate for them. The prescriber named on the PharmaDoctor website was different to the one on the prescriptions supplied by the pharmacy, which was misleading and could cause confusion in the event of a query or error.

The pharmacy’s registration number, address and contact details, and the name of the owner and SI were on the website. The pharmacy manager pointed out that the name of the prescriber was on the pharmacy's website and the country he was registered in, and there was a link to his registration status. However, this was not prominently displayed and there was no information available about their indemnity arrangements.

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 and sold via the website are appropriate for the people they supply. It supplies some medicines which may not be appropriate for supply via a remote consultation using online questionnaires because they require physical examination, blood tests or monitoring. The pharmacy supplies medicines without informing the patient's regular doctor. This means their condition might not be properly monitored, and their use of medication may not be adequately controlled.

Inspector's evidence

This was a closed pharmacy which provided its services to people at a distance. Information about the pharmacy's services and operating hours were available on its website. There was some health information on the different conditions on the website and blogs on topics such as hayfever and pain. People could contact the pharmacy by email. Two telephone numbers were provided on the website but calls were not always answered when the pharmacy was contacted following the inspection.

People wishing to purchase P medicines via the internet were required to answer a small number of questions. These were reviewed by the pharmacist before allowing the supply. The questions were generally the same for all the P medicines although some additional information was required for medicines for thrush and EHC. Records of sales were recorded for each customer, so patterns could be monitored. Some blocks were built into the website to prevent over-ordering. For example, only one packet of a codeine containing product could be sold at a time. However, it could be purchased again after an interval of one month. Additional checks were made by the IT team when people requested opioid containing medicines, sedatives or laxatives. Names, addresses and IP addresses were checked for multiple accounts and the date of the last supply was noted. Some sales were 'stopped' because they didn't pass these checks and the person could be blocked on the website to prevent further orders from being placed. This functionality was all manual and there were no automated flags to highlight any duplicate accounts or inappropriate supplies. During the previous week, 24 pharmacy medicines supplies had been stopped including:- Phenergan tablets, Nurofen plus, Solpadeine and kaolin and morphine mixture, and 15 of these were because they were repeated orders within one month. None of these customers had been signposted for support with addiction. An example was found which would indicate that a person might be overusing codeine containing medicines. They had obtained Solpadeine or Nurofen Plus from the pharmacy for four years and had received eight orders over the last twelve months. This was not in line with the current guidance which specifies that medication containing codeine is for short-term use only and for a maximum of 3 days. The person had not been signposted to their GP for a review of their condition, or for further support. Another patient made two multiple orders overnight for Phenergan. This was identified and the second order stopped, but the pharmacist was not notified and one of the supplies was permitted. There was a checking bench which contained baskets of P medicines ready for a check by a pharmacist. Most of these contained large quantities of medicines. For example, 500 Piriton tablets (which is a sedative) and a year's supply of non-sedating antihistamines. Some orders were for large quantities of treatments for vaginal thrush including fluconazole and clotrimazole which does not promote good antimicrobial stewardship.

People requiring a POM, completed an online consultation, however the questions were set up so that

it was clear which answer would prevent the supply of the medicine. The person was then allowed to change their answer without any record of the change being made. No evidence was required to verify the information they had entered was correct. This was a risk because people might accidently or deliberately enter incorrect information in order to receive a supply. There was no question that explicitly asked a patient to consent for the prescriber to contact the GP. There was a request at the checkout stage, but this came with the warning that this might delay the person receiving their medication. This would probably deter most people from choosing this option. The RP did not know if anybody's prescription details had been shared with their usual prescriber. There was no proof required that a person was asthmatic or any questions about the use of a preventer inhaler during the asthma consultation. Consent was not requested to view the patient's SCR. The RP was unable to contact the prescriber directly and had to relay any messages via the pharmacy manager. The pharmacy manager stated he rarely had concerns to communicate to the prescriber and could not think of any examples. The RP did not usually have access to the consultation completed by people for supplies of POM medication, which compromised the effectiveness of her clinical check.

The weight loss treatment page had a Body Mass Index (BMI) calculator for the person to enter their height and weight. The calculator then informed the person whether the treatment would be suitable for them or not. This was before the consultation. When the consultation started it stated: "is your BMI over 30. Or over 28 if you have a listed condition". If a correct answer was given a response appeared stating "Based on your answer our Prescriber can prescribe this medication. Please continue with your online consultation." If no was selected the following response appeared "Based on your answer our prescriber cannot evaluate your consultation." So, a person could alter their response in order to obtain the medicine, without the prescriber knowing. There was a reliance on the customer to determine whether they have lost 5% of their body weight in 3 months, which was a threshold for continuation of treatment for Saxenda and orlistat. Patients were provided with only limited information and they were generally directed to NHS website for counselling points.

All medicines were posted by a Royal Mail service which could be tracked by the pharmacy. A very small number of NHS prescriptions were dispensed, less than 20 each month. These were usually from members of staff and their friends and family, so they did not require delivery or postage.

Space was adequate and the workflow was organised into separate areas with designated checking areas. The warehouse and dispensary shelves were reasonably neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels of POMs and picked by, packed by and checked by details were recorded for P medicines to provide an audit trail. Baskets were used to improve the organisation in the dispensary and prevent orders becoming mixed up. The baskets were stacked to make more bench space available.

Recognised licensed wholesalers were used to obtain medicines. Medicines were stored in their original containers. Date checking was carried out and documented. Expired medicines were segregated and placed in designated bins. There was a controlled drug (CD) safe in the pharmacy but schedule 2 and 3 CDs were not usually stocked or supplied by the pharmacy. Two packets of Saxenda injections were stored in a fridge on the mezzanine floor, which was normally used for wholesaling. The thermometer associated with the fridge was recording 17.5 degrees Celsius. The maximum temperature was recording 33.1 and the minimum 0.2 degrees Celsius, which was outside the required range. The business development manager did not know if the thermometer was working or if it had ever been re-set. She believed the fridge was being monitored but couldn't locate any records for this. The staff from the wholesaling team were not present to check if they were monitoring the temperatures. When the temperature of the fridge was pointed out to the business development manager, she removed the Saxenda from the fridge and wrote 'to be destroyed' on them.

There were three or four plastic tote trays containing returned medicines. The warehouse manager said they were mainly OTC medicines. He said they would be examined and if the packaging was in good condition, they were returned to stock to be re-used. However, the storage conditions of these medicines whilst they had been away from the pharmacy was unknown, so they might not be fit for use. The warehouse manager said they very rarely received POMS back, but they would not be re-used. Following the inspection the SI stated they occasionally recycled non-medicinal products, but never any type of medicines.

Alerts and recalls were received via email messages direct from the Medicines & Healthcare products Regulatory Agency (MHRA). These were read and acted on by a member of the pharmacy team, but they were not retained so they would not easily be able to respond to queries and 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.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information. Electronic versions of the BNF and medicines compendium (eMC) were available. All electrical equipment appeared to be in good working order. There was a small selection of equipment for measuring liquids and counting loose tablets and capsules, but this was very rarely used, as medicines were usually supplied in their original container. The pharmacy manager confirmed that IT met the latest security specification and Secure Sockets Layer (SSL) was installed on the webserver for website and data security. This was a computing protocol that ensured the security of data sent via the internet by using encryption. 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.