General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy2U Ltd, Unit 4B, Victoria Industrial Park, Victoria Road, Leeds, West Yorkshire, LS14 2LA

Pharmacy reference: 9010146

Type of pharmacy: Internet / distance selling

Date of inspection: 03/03/2022

Pharmacy context

This pharmacy provides its services at a distance and access to the premises is closed to the public. People visit the pharmacy website and contact the pharmacy using a variety of methods including telephone and email. The pharmacy business is a large operation across two sites. The registered pharmacy premises are supported by teams based at another site nearby. The pharmacy's main activity is dispensing NHS prescriptions. And it supplies some medicines from the online private prescribing service, including for medical conditions such as weight loss. The pharmacy provides the NHS COVID-19 vaccination service at several associated premises across England. The pharmacy was inspected 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 met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy actively encourages and supports team members to develop their knowledge and skills. It provides a range of opportunities for team members to identify their training needs and it gives them protected time to complete their training. The pharmacy is good at giving team members regular feedback on their performance. This means team members benefit from identifying areas of their own practice they wish to develop to keep their skills and knowledge up to date.
		2.5	Good practice	The pharmacy proactively encourages team members to share their experience and ideas on how to improve the efficient delivery of services. And team members respond by regularly engaging in feedback to identify improvements to the delivery of pharmacy services. They suitably act to introduce processes to improve their efficiency and safety in the way they work.
3. Premises	Standards not all met	3.1	Standard not met	People accessing the online doctor prescribing service through the pharmacy's website can select a prescription only medicine, its strength and quantity before completing a consultation for their condition. This is not in line with GPhC guidance.
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

The pharmacy teams generally identify and manage the risks associated with the pharmacy's services well. Team members follow up-to-date written procedures and they are adept at responding to errors they identify whilst dispensing. They mostly respond to people's concerns well and listen to their feedback. The pharmacy generally completes the records as it should. It holds some suitable risk assessments for the private online doctor prescribing service. But the pharmacy doesn't complete audits for all the medicines it supplies, including some higher risk medicines. These audits help to provide assurance people receive appropriate treatment.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. It had several measures to ensure effective infection control. It had rearranged the teams' workstations at the start of the pandemic to allow for social distancing. And it had installed plastic barriers in areas where team members worked opposite each other. Team members wore face coverings unless they were working in an office on their own. The pharmacy's business continuity plan allowed for workload to transfer between two of its pharmacy sites during times of absences. And many team members were provided with equipment to work from home. The pharmacy had completed a home working risk assessment covering issues such as arrangements to ensure people's confidential information was protected.

The pharmacy had a wide range of up-to-date standard operating procedures (SOPs). These provided the teams with information to perform tasks supporting the delivery of services. Each SOP had a detailed record of when a review and update had taken place and the team member who had completed the review. The pharmacy kept electronic records of the statements made by team members that they'd read and understood the SOPs. The team members demonstrated a clear understanding of their roles and when to refer queries to senior team members.

The pharmacy provided NHS and private pharmacy services including a private online doctor prescribing service regulated by the Care Quality Commission (CQC). Prescriptions from this service were clinically assessed and dispensed alongside NHS prescriptions by the pharmacy. Two employed UK based medical prescribers registered with the General Medical Council (GMC) prescribed for the service. People accessed both the private online doctor service and NHS services via the pharmacy's website. For the online doctor service, people completed an online consultation questionnaire that was reviewed by one of the prescribers and this informed their prescribing. The pharmacy held a risk assessment for the service that was categorised into the different conditions and also in some cases for specific treatments for example, for Saxenda and Mysimba. The pharmacy held guideline documents for the treatments and medicines offered on the website. These provided an aide memoir to the prescribers in addition to the information they would access via sources such as the manufacturer's summary of product characteristics (SPC). The weight loss treatment guideline included reference sources such as the National Institute for Health and Care Excellence (NICE) and had been reviewed by one of the prescribers in April 2021. This included suitable treatment guidelines for orlistat, Saxenda and Mysimba. There were audits relating to the prescribing of some medicines. This included an audit relating to antibiotic prescribing for a range of conditions and had been completed annually from 2018-2021. The results showed a reduction in prescribing of antibiotics. The team recognised during a review meeting an increase in the prescribing and supply of Mysimba for weight loss and agreed to review

weight loss treatments. Mysimba and Saxenda were identified through reports as being on the top 10 list of medicines prescribed. But there was no documented review or audit of these treatments demonstrated to show supplies of these medicines were appropriate. The pharmacy completed some level of review of the email queries between the pharmacists and prescribers to identify trends and near misses. There was evidence through meeting minutes that there was ongoing review of treatments. For example, the minutes from the meeting in January 2022 showed propranolol M/R being stopped, as it was not licenced for the medical condition it had been prescribed for. And the medicine was removed from the pharmacy's database so it couldn't be prescribed. The team agreed a limit on the propranolol dose prescribed as it considered the person's GP should manage higher doses. Records were held of prescription requests approved by the prescriber and ones that had not. This provided reassurance of interventions preventing the inappropriate supply of medicines by the pharmacy.

The pharmacy had procedures for managing errors identified at the different stages of dispensing a prescription and it kept electronic records of these errors known as near misses. It kept the electronic records readily available, including on computer terminals close to where team members worked, to enable them to promptly complete them. The team member involved with the error, including pharmacists, had the opportunity to discuss it so they could reflect on what had happened and learn from it. A sample of completed records showed detailed information was captured such as the area in the pharmacy the error occurred and what had been prescribed and dispensed. This helped the teams spot patterns. The pharmacists used a separate template to record errors with prescriptions containing controlled drugs (CDs).

The pharmacy had a quality assurance (QA) process and a dedicated QA team. They received errors identified at any stage in the picking, dispensing, checking, and packing stages. For example, when a tote box contained more medicines than listed on the prescription order. The QA team logged the error and identified where in the process the error occurred and why. This information formed part of the pharmacy's review of processes and was used to provide additional training for team members.

The pharmacy mostly received notification of dispensing incidents when the person contacted the customer care team. The team had processes to identify if the person had taken the incorrect medication and the degree of urgency. Additional information, including photographs was requested and the team member recorded the error electronically so all team members could view the report. Pharmacists received notification of the incident to check if any urgent action was required. And one of the specially trained technicians or dispensers investigated the error identifying actions to address the root cause. They accessed CCTV footage on occasions to help with identifying the cause. Senior pharmacy team managers monitored the completion of the investigation. If the person made a formal complaint, or experienced harm, one of the pharmacists completed an additional dispensing incident report. The pharmacy ensured all team members whether they were involved or not were advised of the dispensing incident.

Senior team members regularly created reports and graphs to identify trends from errors. And they shared the data, the outcome and learning with all team members via email and an internal online platform. There was an emphasis on accuracy rather than speed. The line managers increased support through one-to-one meetings or additional training if required. Team members reviewed and discussed their near misses together and shared case studies to learn.

The pharmacy website provided people with details on how to raise a concern. And it had a section covering frequently asked questions to help people resolve their query. People sometimes reported difficulties contacting the pharmacy. The pharmacy recognised this and had installed additional communication tools to the telephone and email options. Many people used a digital platform when engaging with the pharmacy which also had a Live Chat function. The pharmacy encouraged people to

use the Live Chat function as a way of receiving a quicker response. People left messages out-of-hours for the team to respond to the next working day. And it aimed to have all requests from people for a call back to be completed by the end of the working day. The training provided to the customer service team included the knowledge and skills to handle and resolve most concerns raised by people. The pharmacy also had a dedicated complaints team that managed people's concerns and provided support to the customer service team. The pharmacy sourced feedback from people using a popular online platform and on social media platforms. The pharmacy monitored feedback left by people throughout the day so it could respond to queries raised. The pharmacy used the feedback it received to inform discussions amongst team members and senior management. The pharmacy received feedback from people using the private online doctor prescribing service via a survey and individual concerns. The pharmacy shared this feedback with the prescribers so they could review and make any necessary changes.

The pharmacy had up-to-date indemnity insurance. The prescribers providing the online doctor service had their own indemnity insurance. A sample of records for the CD registers met legal requirements. The pharmacy used an electronic spreadsheet as the Responsible Pharmacist (RP) record, but the cells and spreadsheet were not protected so entries could be amended or removed. The RP on duty displayed their RP notice. The pharmacy had electronic CD registers and it had several internal systems to record and monitor CD receipt, management, and supply. The pharmacy regularly completed a CD balance check. This was undertaken at a time when all prescription orders had been processed and there was no movement of CD stock to ensure there was an accurate balance. This process was captured on the pharmacy's internal stock management system but not in the CD registers. After the inspection the pharmacy provided an updated version of the SOP for checking CD stock which included the recording of the balance check in the CD register. The balance for one CD register was incorrect as out-of-date stock had been removed from the balance but was waiting to be appropriately destroyed. After the inspection the pharmacy provided an updated version of the SOP for the disposal of out-of-date CD stock which stated expired stock should be captured in the CD register until destroyed. The CD registers recorded who had accuracy checked the CD prescription, which was not always a pharmacist. The RP at the time of receipt and supply was not recorded in the CD register.

The pharmacy provided regular training and guidance to the teams on confidentiality and data protection. And there was a confidentiality clause embedded into each team member's employment contract. The pharmacy had a dedicated data protection officer and data protection team who frequently updated all the teams with new information or changes. The pharmacy website displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a separate privacy notice. The team separated confidential waste and stored it securely for shredding offsite. The pharmacy provided the NHS new medicines service which involved the pharmacists contacting the person. Sometimes the pharmacist supporting the service worked from home. In this situation the pharmacy provided the pharmacist with laptops to access the pharmacy's system and the person's information. The pharmacy had completed a risk assessment of this service. This included identifying and addressing risks to people's confidential information. However the RP at the time of the inspection had not seen the working from home policy or was aware of signing a confidentiality clause.

The pharmacy had safeguarding procedures and guidance for the teams to follow. The pharmacists completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The pharmacy teams completed internal on-line training modules. The teams had examples of where they had responded appropriately to potential safeguarding concerns. The pharmacy held records showing that the prescribers providing the private online doctor service had completed appropriate safeguarding training. The risk assessment for the online doctor service included risks associated with potential inappropriate prescribing for children. And the mitigation stated the use of a recognised ID checking system. No audits were demonstrated of checking the use the ID system to

prevent people, including vulnerable people and children, from inappropriately accessing medicines through the service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large and experienced team with a wide range of skills to support its services. It actively reviews the team members' workload to ensure they work safely and efficiently. The pharmacy is good at supporting new team members with a structured learning programme. And it consistently provides ongoing training and development opportunities for all team members to progress their knowledge and skills. The pharmacy takes responsibility to regularly engage with team members to identify areas for improvement. And it actively responds to this feedback. But it doesn't always fully engage with the responsible pharmacist to ensure they are aware of their responsibilities for all the services the pharmacy provides.

Inspector's evidence

The pharmacy team across the registered pharmacy site and a linked local non-pharmacy site consisted of the Superintendent Pharmacist (SI), a deputy SI who was also the patient safety manager, and a senior pharmacist. The pharmacy employed 11 full and part-time pharmacists along with locum pharmacist support when required. The remaining members of the pharmacy team comprised of, two pharmacy technicians, eight accuracy checking technicians (ACTs), five trainee technicians, 19 dispensers including some accuracy checking dispensing assistants (ACDA) and six trainee dispensers. A number of team members did not hold a pharmacy qualification. They were suitably trained for their roles and the tasks they performed.

A goods-in team, a manual picking team and a packing team worked from the registered premises. The pharmacy offered dispenser training to members of these teams after they'd completed their initial 12-weeks training and induction as a way to progress. The dispensing course was specific to the understanding of their role in the accurate picking and processing of prescriptions. These teams had a clear management structure and team members knew their roles and tasks. They worked systematically and efficiently at their allocated stations and within their allocated teams. If the workload built up in one area the managers reallocated other team members to manage the backlog. The RP usually worked in an office with no direct visibility of the dispensing processes and of other aspects of the pharmacy operations in the warehouse. The RP could enter the warehouse to gain reassurance of the daily operation, but this was not a designated task and was the decision of the individual RP.

Several teams worked at the other site owned by the pharmacy business. The pharmacist clinical team and the pharmacy prescription labelling team were based at this site. Along with the medical prescribers providing the private online doctor service. The site also housed the customer service team and the registration team. The pharmacy's internal communication systems ensured team members across both sites could effectively respond to colleagues' queries. For example, the pharmacist team had a generic email box for all teams to use which was regularly checked by the pharmacists. Senior team managers frequently visited both sites to ensure there was regular contact with all the teams and to provide support when required.

The team providing COVID-19 vaccination services at associated premises across England, consisted of seven pharmacists and 32 nurses. The SI provided oversight to the teams at the associated premises to ensure appropriate supervision and governance. During the inspection the Responsible Pharmacist (RP) at the registered pharmacy was the only pharmacist on-site and initially this was a locum pharmacist.

After their shift ended an employed pharmacist took over as RP. Both RPs were not aware of their role and responsibilities for the associated premises as this had not been communicated to them. Following the inspection, the pharmacy sent a copy of a statement regarding the vaccination services given to RPs when they signed in at the pharmacy. The statement explained the services being provided at the associated premises. And the role of the team members at the sites, along with the role of the SI and the RP when these services were being provided.

The pharmacy provided a structured training and induction programme for new team members. And it allocated less experienced team members to areas suitable for their knowledge and experience so they could learn and develop before potentially moving to other areas of the pharmacy operations. The pharmacy had a stand-alone coaching team who provided one-on-one coaching at the workstations and also observed performance through CCTV monitors placed at the workstations.

All team members had access to ongoing e-learning training and they had protected time at work to do the training. The pharmacy kept training records for the teams, which the line managers used to monitor completion and to provide support to team members if needed. The line managers also held monthly meetings with team members enrolled onto training courses to check on the trainees' progression and see if they needed extra support. The managers increased these to weekly meetings if needed. The pharmacy issued a company newsletter to provide the teams with up-to-date information. The pharmacists at the registered pharmacy often met with the pharmacists in the clinical team to keep their knowledge up to date.

The pharmacy provided team members with feedback on their performance through informal one-to-one sessions and a formal performance development review (PDR) process. And it captured detailed records of the PDR meetings for the team member to refer to. The pharmacy actively celebrated team members' success with meeting personal objectives. The pharmacy supported team members' personal development through opportunities to work in other teams and to take on new roles and responsibilities. And it offered training such as management courses for team leaders. The pharmacy managers had identified team members keen to take on new responsibilities. And they had become experts in specific roles. For example, three ACTs had received training on the NHS discharge medicines service (DMS) and were classified as DMS experts. The pharmacy was keen that team members understood that although it operated from a large warehouse with a degree of automation it was a pharmacy providing people with their medication and its warehouse operatives were employed as Pharmacy Facility Operatives. This helped distinguish it from other warehouse settings. It encouraged team members not directly involved with dispensing prescriptions to learn the names of medicines and recognise packs to develop their pharmacy knowledge.

The pharmacy supported individual teams including the prescribers to meet on a regular basis. And the teams kept records of the discussions held at these meetings. The pharmacy had a whistleblowing policy and provided team members with training. Team members felt comfortable raising concerns with their line manager and if necessary, with the SI. The pharmacy provided all team members with the opportunity to provide feedback using annual surveys. And it gave team members protected time to complete the survey. The pharmacy summarised the outcome from the survey in a presentation to all team members. And it used the feedback to make appropriate changes. Team managers asked for feedback on what could stop, start, and continue within the teams' processes and procedures. Several examples were demonstrated of changes made following team members feedback. The manual picking team had recently altered its way of working. This involved altering the number of tote boxes being processed at one time to help workflow. The pharmacy was analysing the data to ensure the change was positive.

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

Summary findings

People access services through the pharmacy's clearly laid out website. But in some areas of the online doctor prescribing service section, people can select a medicine and quantity before they complete a consultation for their condition. This is not in line with GPhC guidance. The pharmacy premises are large and appropriate for the services provided. And the pharmacy is suitably clean, hygienic, and secure.

Inspector's evidence

People did not directly access the pharmacy premises which were in a large warehouse facility. This provided plenty of space for team members to work and for storing stock. The team members kept the areas clean and tidy and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had health and safety procedures for the automated parts of the process to help keep the teams safe. The pharmacy had separate sinks for the preparation of medicines and hand washing with hot and cold water available. Sufficient staff facilities were available. The pharmacy had systems installed to secure the premises. And it had an intercom to manage visitors and access to the premises. The pharmacy had clearly marked fire exits.

The pharmacy's website provided people with information on the services offered, the operating hours and contact details for the pharmacy. It also had a help and support section providing people with information on a range of subjects including how the person could update the pharmacy with their personal details. People accessed NHS services and the private online doctor service via the pharmacy's website. The website had a section to "Meet the Team" and this included details of the Superintendent Pharmacist, senior pharmacist and the two prescribers for the online doctor service. The home page for the online doctor section of the website provided information on how the service operated and reference to its CQC registration. It then invited people to access information on separate pages for specific conditions. The specific conditions page provided information on the condition and on the different available treatments. People then started a generic consultation questionnaire to obtain suitable treatment. This met GPhC guidance. The website made it clear that whilst the decision about medical treatments was for both the prescriber and the person to jointly consider, the final decision on the medicine prescribed was that of the prescriber. But on different pages on the website people could choose a specific medicine, the strength and quantity they wanted, before the consultation questionnaire was started. This does not meet with GPhC guidance. Following the inspection and receipt of the GPhC improvement action plan the pharmacy changed its website. The option for a person to choose a specific medicine, the strength and quantity they wanted, before the consultation questionnaire was started was removed. This meant people had to complete the consultation for their condition before they were given the choice of suitable treatments.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to a large number of people. It generally uses automation systems to support the safe delivery of its services. It adequately reviews its systems and processes to safeguard the health of people. And it generally takes appropriate action to ensure the delivery of its services remain safe and suitable. The pharmacy gets its medicines from reputable sources and the team members store them properly. They check stock levels and ensure medicines are suitable to supply. However, they don't always keep people adequately informed of delays to the receipt of their medicines, due to issues such as out-of-stock items.

Inspector's evidence

The pharmacy supplied placebo and active stock for a clinical trial led by Bristol University. A team from Bristol University visited the pharmacy before agreeing the service. And had provided appropriate training for the members of the pharmacy teams that supported the service. Pharmacists checked the prescriptions before sending them for processing. The pharmacy received pre-packed placebo stock and active stock from the company involved in the trial. And stored the packs in a dedicated area of the pharmacy.

The pharmacy provided the NHS COVID-19 vaccination service and the seasonal flu vaccination service at several associated premises. The pharmacy had a dedicated team managing the service. And had completed risk assessments for all associated premises which were regularly reviewed by a senior team member. There were appropriate governance arrangements between the vaccination sites and the dedicated team and the SI. But the RP signed in at the registered premises did not have an integral role. Following the inspection, the pharmacy introduced additional information for the RP regarding the vaccination service to keep them suitably informed. The pharmacy held weekly meetings with the team at the associated premises to discuss a range of matters including feedback from people using the service and reported incidents.

As part of the private online doctor prescribing service, once people accessed the service and submitted their consultation questionnaires, their details went through an ID check, using a recognised system. This was used to identify duplicate and inappropriate requests and to help ensure supplies of medicines were appropriate. One of the prescribers reviewed the consultation questionnaires. They referred to national guidance and had internal guidelines. These internal guidelines were designed, reviewed, and updated with input from the pharmacists. The treatment guidelines for treating acne had been recently updated to reflect the impact of the condition on a person's mental health. The consultation form was updated to reflect this. The most popular medical conditions people sought treatment for, were weight loss and erectile dysfunction.

The consultation questionnaire asked people if they agreed to provide consent for their NHS GP to be informed. Safeguards were in place to help prevent prescriptions for propranolol being issued without consent being provided. This helped to ensure supplies of this medicine were appropriate. There was a repeat prescribing and treatment policy SOP. People were required to complete a new questionnaire for each request for weight loss treatment and also propranolol due to the increased risks and requirements for ongoing monitoring. The supplies of these medicines were limited to a maximum number of requests due to the risk of misuse, although an audit of compliance to this wasn't demonstrated. Prescribers and the pharmacists completing the clinical check of the prescription,

monitored for repeat requests from people for the same medication. One example seen showed where a person had accessed the online doctor service and been supplied with a medicine, only for the pharmacy to receive an NHS prescription for the same medicine a couple of days later. The pharmacy team liaised with the person's NHS GP to ensure they didn't receive duplicate supplies of the medicine. People received advice from prescribers about their medical condition and the medication prescribed in several ways such as email or by telephone. The prescriber's login was described as a unique log in and that the system generated the electronic private prescriptions in a way that signatures could not be modified. The prescriber's details were visible on the private prescribing log and they documented records such as the person's treatment plans on to an electronic prescribing system. This information was not visible to the pharmacists completing the clinical checks, but the pharmacists had visibility of people's answers from the online consultations to inform their clinical check decisions. They emailed prescribers with queries and kept a record of their contact with prescribers. Once the pharmacist had completed the clinical check, the medicine was dispensed in the pharmacy alongside the NHS prescriptions and delivered out in the same way.

The pharmacy's website provided details on the process for registering to access the pharmacy's NHS services. The registration process included a record of consent from the person to use the services and details of the person's representative when they'd applied on the person's behalf. The pharmacy accessed a secure website to verify people's NHS numbers using three pieces of information provided by the person, which had to match the details from the website. This ensured accuracy of information submitted and that the pharmacy was complying with data protection legislation. The registration team contacted the person when there was a failed nomination to ask for specific information to complete the application. The pharmacy usually returned any prescriptions to the NHS spine if it had not received a response following several attempts to contact them. The pharmacy followed a similar application process for people presenting private prescriptions or using the pharmacy's online doctor service. And marked the person's account to indicate whether they had NHS or private prescriptions. The pharmacy's system highlighted people with similar names so all team members were alert to this when processing the prescription.

On most occasions the registration team established with the person how much medication they had to ensure they had enough before the supply came from the pharmacy. The registration team used information from the prescriptions such as the person's age and whether the medication was prescribed in weekly quantities to complete a vulnerable person check. This often-triggered contact with the person usually by telephone to confirm the person had intended to nominate the pharmacy and whether they had any medication needs. This enabled the team to discuss any support a person may need such as having their medication supplied in multi-compartment compliance packs. The registration team updated the person's account with this information so it was visible to all team members. On occasions when the pharmacy didn't supply medication in accordance with the information on the person's account the team members involved were asked to reflect on why this had happened and were re-trained on the process.

The pharmacy's website provided people with information on the usual timescale for ordering and supply of prescriptions. And it prompted people to order their prescriptions in advance if the supply was due over bank holidays. The pharmacy requested some people's prescription on their behalf. And generally started the process 10 working days before the supply was made. The person could respond on several platforms including the pharmacy's mobile phone App or an automated telephone system. The pharmacy recorded the contact made and the team members normally used this information to check for a response from the person. So, they could send a reminder.

The pharmacy received most NHS prescriptions electronically (EPS). But some came through on paper forms and were transcribed onto the pharmacy's system and checked by a pharmacist. The pharmacists

completed clinical checks electronically. The system colour-coded a prescription when a check was in progress to ensure only one pharmacist worked on a prescription at a time. The pharmacists usually accessed the person's summary care records (SCR) as part of the clinical check to ensure they had up-to-date information. And contacted the person's GP with any queries about the prescription. The pharmacy had a dedicated team that sent the pharmacists' queries to the GP teams, recorded this on the system and monitored for a response. The team kept in contact with the pharmacists when there were delays with a response to decide on the next steps. The pharmacists regularly checked the query queue to identify ones with no response and to decide on the next steps. The pharmacy usually informed people when there were delays with the receipt of their prescriptions. Or when prescriptions couldn't be processed as there were items missing. The pharmacy generally kept records of this contact along with brief details of what the person was told. When a person didn't receive notification of problems with their prescription the pharmacy investigated and provided further training to the team members involved. The customer service team highlighted any medicines the person advised they didn't need so the pharmacists and dispensing team were aware of this when processing the prescription.

The dispensers generating the labels checked for electronic messages from the pharmacists to ensure any instructions for changes to labelling were included. The dispensers highlighted information such as when the quantity was not an original pack and when the person preferred a certain brand of medication. ACTs checked the generated labels before they were released, and they sent any errors back to the dispenser for re-labelling. The dispensers generated an owing if the pharmacy’s system flagged there was insufficient stock and contacted the pharmacists to check if there was an alternative product. The pharmacy had a dedicated ‘where’s my order team’ who managed out-of-stock items and liaised with colleagues in other teams. When this team was aware of products that the manufacturer couldn’t supply it contacted the manufacturer to establish how long the product would be unavailable. On most occasions the pharmacy advised people when their medication was not available, usually using an automated email. The customer service team normally checked for a response from the person and sent a reminder email if they’d hadn’t replied. However, some people had experienced delays with the receipt of their medication due to stock shortages that they hadn’t been aware of. When the pharmacy was informed of this the team members involved were normally advised and provided with additional training. The pharmacy prioritised prescription orders that had owings.

The pharmacy used an automated system for picking many of the prescribed items. And it stored items such as liquids, fridge lines and CDs in dedicated areas for manual picking. The pharmacy used large tote boxes to carry the stock for each prescription order. It had a bar code attached that was unique for each prescription order. A team of trained dispensers managed the automated picking system. It used CCTV and computer data to monitor the automation process to identify any problems. The pharmacy’s manual picking process consisted of scanning bar codes to ensure the correct product was selected and a pick-by-light system that indicated the section holding the stock to be picked. The team placed fridge lines into a dedicated bag before placing it in the tote box. A team of dispensers completed the dispensing process by attaching the label to the picked products. They used a bar code system to match the prescription with the item picked and the label details. The dispensers referred to the notes about the order such as the flavour of drinks requested.

The pharmacy provided many people with their medication in multi-compartment compliance packs. A dedicated team supported this service and worked in a defined area of the pharmacy and team members worked at separate workstations to promote efficient workflow through the area. Each person had a chart listing their current medication and dose times which was checked by the pharmacists. The team referred to the chart when dispensing the medication into the packs. The team members wore gloves when dispensing the medication into the packs. They had a list of cytotoxic

medicines at their workstations and changed their gloves after dispensing these medicines into the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The ACT in the team checked the completed packs before sealing them for dispatch and made a record of this on to a dedicated spreadsheet. If the prescription for a pack contained other medicines the pharmacy didn't release them until the packs were ready to be supplied.

The ACTs and ACDAs completed accuracy checks on some of the prescription orders. This included randomly selected orders from the automated picking process, all CDs and prescription orders containing spilt packs. The team member completing the accuracy check referred to the notes on the person's account when undertaking the check. The pharmacy kept an electronic audit trail of which team member was involved in the different stages of dispensing and checking the prescription. Team members responsible for packing the completed order ready for dispatch used a bar code system to match the number of items with the order. And that the person's name and address were correct on the dispatch label. The pharmacy displayed posters reminding the team member to always check the person's name. The team member was alerted to orders containing a CD that had to be retrieved from its secure storage.

The pharmacy used discreet packaging and it generally used a UK-wide delivery company. The pharmacy used the delivery company's tracking service and could upgrade orders from a 48-hour delivery to 24-hour delivery at any point in the processing of an order if an urgent supply was needed. The pharmacy reviewed and monitored the delivery company's performance to ensure it met the service levels agreed. The pharmacy's website provided people with delivery information and how to track the progression of their delivery. Some people had given consent for their medication to be put through their letterbox. The pharmacy asked the person specific questions such as whether there were children or pets at home before this was agreed. But the details of what was asked were not captured on the system, it only showed a yes or no response to whether consent had been obtained. The pharmacy asked the person to advise if the circumstances changed so the letterbox delivery option could be reviewed. But the pharmacy didn't have a process to repeat these questions after a certain timescale to confirm this delivery arrangement remained safe. The pharmacy offered people a safe place option for certain medicines. This was recorded on the person's account along with details of where the safe place was. There was no evidence that the pharmacy monitored these delivery options to identify any concerns and to ensure supplies were made safely. The pharmacy usually contacted the person when there was a failed delivery. And the medicines were returned to the pharmacy. The pharmacy's SOP covering failed deliveries stated CDs subject to safe custody should be re-entered back into the CD register. But further in the SOP it stated that failed CD deliveries should not be entered back into the CD register and must be treated as a patient return and destroyed, creating confusion in the process. The pharmacy updated the SOP after the inspection to make it clear the difference was for CDs returned to the pharmacy when no attempt at delivery had been made. And CDs returned to the pharmacy after an attempt had been made but the person was not at home to receive the CDs.

The pharmacy obtained its medicinal stock from several reputable sources. And it had a purchasing team responsible for monitoring stock levels and generating a daily report on stock shortages. The team receiving stock from the wholesalers checked the expiry dates on the products before adding them onto the pharmacy's electronic stock system. The pharmacy had a separate team managing the receipt of unlicensed medication who assigned codes to the products to track them through the system. After an error with the supply of an unlicensed medicine the pharmacy introduced a step where an ACT checked the code and product alongside the information on the pharmacy's system to ensure they all matched. The pharmacy's SOPs enabled named pharmacy team members to accept CDs from the

wholesaler. The SOPs clearly stated that the RP remained accountable for the receipt and storage of the CDs. The CDs were recorded in the CD register, on to the internal stock system and on to a spreadsheet. The spreadsheet recorded which team member had received the CD stock which was used when completing the entry in the CD register. This spreadsheet was visible to the RP for checking.

The pharmacy had two large, open-fronted fridges holding stock. These fridges were connected to an alarm if the temperature went outside the accepted range. Team members working on call were linked to the alarm in case it was triggered outside of the normal operating hours. The pharmacy had a back-up generator that provided 24 hours electricity in the event of a power shortage. And it tested the generator twice year to ensure it was working. The pharmacy had several back up stock fridges and the temperature of these were recorded twice a day. A sample found the temperatures within the correct range. The pharmacy undertook regular checks on the expiry dates of stock. And the automated stock handling and picking systems captured the expiry dates of products to reduce the risk of short-dated stock being selected. The pharmacy team generally checked expiry dates on stock when dispensing to see if the dose and quantity prescribed would fall within the timeline of the expiry date of the product. The team marked products with a short shelf life once opened and included the date the item would expire. When the team split the original manufacturer's pack to fulfil a prescription it attached a bar code to the packaging before returning it to the robot or placing it on dedicated shelves. The split pack was labelled to show the remaining quantity and the pharmacy's internal system prompted these packs to be used first. The team regularly checked the section holding split packs to remove any out-of-date packs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has equipment in its warehouse facility that is well maintained to help ensure the safe supply of medicines. The pharmacy's systems suitably protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used automated technology for picking most of the prescribed items. Three large robots stored most of the medicines. And fast-moving medicines were stored in a 'pick by light' area. A dedicated team who had completed NVQ2 dispenser training filled the robots with stock and monitored the robots' performance using CCTV images and computer data. The monitoring element included ensuring the stock from the robots was completely transferred into the tote boxes. The team checked any rejected tote boxes to establish why the tote and prescription order was rejected. The pharmacy used specific packaging when delivering fridge lines to people to help ensure they remained at the correct temperature. The pharmacy completed an annual test of the packaging by sending a fridge line to a senior team member who checked the medicine was at the correct temperature on receipt.

The pharmacy computers were password protected and data was encrypted to ensure people's confidential information was protected. The pharmacy held people's data in its cloud-based system which was regularly backed-up. There was access to IT support 24 hours a day, seven days a week. The pharmacy had completed risk assessments for team members working from home. This included whether the team member had the correct equipment to support the tasks they were performing and to ensure confidential information was protected. The pharmacy provided team members working from home with headsets to ensure conversations were kept confidential. The pharmacy had systems in place and information for team members to support their health and safety whilst at work. The pharmacy displayed its health and safety policy. And it had clearly marked first aid points that included a defibrillator.

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.