

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: 05/12/2022

Pharmacy context

This pharmacy provides its services at a distance and access to the premises is closed to the public. People visit its website and contact the pharmacy using a variety of methods including telephone and email. The pharmacy business is a large operation across two sites with the registered pharmacy premises supported by teams based at another site nearby. Its main activity is dispensing NHS prescriptions and it also provides a private online prescribing service for medical conditions such as weight loss. It provides services such as the seasonal flu vaccinations at several associated premises.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy regularly records, reviews and monitors errors that occur during the dispensing of prescriptions. It uses the information from these reviews to raise awareness with team members and to support their knowledge and understanding. It implements comprehensive changes to processes to support the safe delivery of pharmacy services when it identifies patterns with errors. And senior members of the pharmacy team proactively review all errors.
2. Staff	Good practice	2.2	Good practice	The pharmacy actively supports team members to develop their knowledge and skills. It provides a range of opportunities for team members to identify their training and development needs. And it gives them protected time to complete their training. Team members receive encouragement and help to take on new roles and responsibilities.
		2.5	Good practice	The pharmacy is good at listening to team members and giving regular feedback on their performance. So, they benefit from identifying areas of their own practice they wish to develop. The pharmacy proactively encourages team members to share their experience and ideas so they can improve the efficient delivery of services.
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

The pharmacy suitably identifies and manages the risks associated with its services. It has up-to-date written procedures that the pharmacy teams mostly follow. And it mostly completes the legal records as it should. The pharmacy uses risk assessments, including for the private online doctor prescribing service. And it audits the medicines prescribed. This helps provide assurance that people receive appropriate treatment. Team members have the knowledge to help protect vulnerable people and they suitably protect people's confidential information. They respond competently when errors occur, and they are good at using information from error trends to prevent future mistakes. The teams adequately respond to people's concerns and they listen to feedback.

Inspector's evidence

The pharmacy provided NHS and private pharmacy services including for a private online doctor prescribing service regulated by the Care Quality Commission (CQC). Two employed UK based medical prescribers registered with the General Medical Council (GMC) prescribed for the service from an agreed range of treatments. The pharmacy identified and managed the risks with delivering its services using risk assessments, audits, and standard operating procedures (SOPs). The risk assessment for the online doctor prescribing service was categorised into the different conditions. And in some cases for specific treatments such as weight loss medicines. New treatments were risk assessed by the pharmacists and prescribers before they were added to the prescriber list. The pharmacy completed audits of the prescribing of medicines to identify any areas of concern and it discussed the outcome from the audits with the prescribers.

There was a wide range of up-to-date SOPs providing the teams with information to perform tasks supporting the delivery of the services. Each SOP detailed when a review and update had taken place and the team member who had completed the process. Team members recorded when they'd read the SOPs to show they understood and would follow them. They demonstrated a clear understanding of their roles and knew when to refer queries to senior team members.

The pharmacy had procedures for managing errors that occurred at the different stages of dispensing a prescription. This included a quality assurance (QA) process supported by a dedicated QA team. The team member involved with the error, including pharmacists, had the opportunity to reflect on what had happened and to learn from it. The pharmacy kept electronic records of these errors and a sample showed detailed information including why the error had occurred. Team members discussed common errors and supported each other to help reduce errors. There was a separate procedure for managing errors that had been identified after the person had received their medicine, known as dispensing incidents. Details of the incident were initially assessed by a pharmacist to identify any urgent action such as sending the person the correct medication. A specially trained team of technicians, team coaches and dispensers investigated the incident and requested additional information such as photographs when required. They recorded the incident electronically so all team members could view it alongside the investigation report. The report showed where in the process of dispensing the prescription the error occurred. And the actions the investigation team had identified to address the root cause of the incident. The pharmacy ensured all team members, whether they were involved or not, were advised of the dispensing incident. So, they could learn from the error and were aware of the actions taken to prevent the same error from happening again. Some incidents were classified as never

events. These errors were classified as preventable due to safeguards in place and team members knew the importance of following procedure to ensure these errors never happened again.

Senior team members regularly assessed all the errors and incidents and captured the key themes on charts to identify patterns and monitor for changes. The outcomes of the assessments were discussed at clinical team meetings and shared with all team members. And they were used to identify team members who required additional training and support. A recent review of the structure of the senior management team had resulted in an increased number of coaches to work closely with team members. The coaches spent time with each team member discussing their errors, and what they had learnt from reflecting on their error. The pharmacy reported this approach led to a decrease in the number of errors across all teams. A recent review of dispensing incidents identified several people had not received their medication in the type of container they'd asked for. As a result, a dedicated area in the pharmacy was created for dispensing prescriptions with specific requests and managed by experienced team members.

The pharmacy had faced challenges with staff numbers in the customer service team which had led to some people experiencing difficulties contacting the pharmacy with resulting complaints being received. Senior managers in the customer service team described how this was being addressed. 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, which they were encouraged to use, before contacting the pharmacy. At busy times the team's focus was on handling telephone queries so people with urgent queries were asked to telephone the pharmacy rather than sending an email. The pharmacy provided an out-of-hours service for people to leave messages for the team to respond to the next working day. And it aimed to have requests for a call back to be completed by the end of the working day. Additional communication tools such as a Live Chat function had been installed. The training for customer service team members helped them obtain the knowledge and skills to handle and resolve most queries. And they were supported by a dedicated complaints team that managed people's concerns. Senior members of the customer service team monitored the workload and response times so additional support could be provided when required. The pharmacy checked feedback from people using online and social media platforms. It used feedback received to inform discussions amongst team members and senior management to identify patterns and to take action to address key findings.

The pharmacy had up-to-date indemnity insurance and the prescribers providing the online doctor service had their own indemnity insurance. A sample of records checked, such as the Responsible Pharmacist (RP) records and CD registers met legal requirements. The pharmacy used an electronic spreadsheet as the RP record, but it was not protected so entries could be amended or removed. This was highlighted at the previous inspection in March 2022. A sample of RP records found the entries were compliant. The RP SOP required any amendments to clearly identify when they occurred and who was involved. However, the RP at the time of the inspection had completed a sign out time before they'd finished. This entry was deleted from the spreadsheet but the change was not recorded. The RP on duty clearly displayed their RP notice. The pharmacy had electronic CD registers and had several internal systems to record and monitor CD receipt, management, and supply. The pharmacy regularly completed a CD balance check to identify issues such as missed entries and kept a record.

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 pharmacy's registration process included a record of consent from the person and a verification check of their NHS number using a secure website. This ensured accuracy of the information submitted and compliance with data protection legislation. The pharmacy provided training and guidance to the teams on confidentiality and data protection. And they securely stored confidential waste for shredding offsite. Team members who

worked from home had laptops to access the pharmacy's IT system which held people's confidential information. There was a risk assessment to identify and address the risks of team members working in this environment. And a working from home policy was in place that team members had read and understood to ensure people's confidential information was protected.

The pharmacy had safeguarding procedures for the teams to follow and they completed internal on-line training modules. The pharmacists completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And 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 it included the use of a recognised ID checking system.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy has a large number of team members with a wide range of skills and experience. And they work efficiently in separate, smaller teams supporting each other in their day-to-day work. The pharmacy is good at providing new team members with a structured learning programme. And it consistently offers 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 their feedback. But it doesn't always fully engage with the responsible pharmacist to ensure they are fully aware of their responsibilities for all the services the pharmacy provides.

Inspector's evidence

Several teams with specific roles and responsibilities worked from the registered pharmacy and the non-pharmacy site. The teams comprised of pharmacists, pharmacy technicians, accuracy checking technicians (ACTs), dispensers including some accuracy checking dispensing assistants (ACDA), a goods-in team, a manual packing team and a customer service team. The senior management team included the Superintendent Pharmacist (SI) and the deputy SI who was also the patient safety manager.

The SI provided oversight to the teams at the associated premises to ensure appropriate supervision and governance. The RP at the registered premises was usually provided with information regarding the services at the associated premises and the role of the team members at these sites. This was covered in the RP SOP which detailed the SI and the RP's responsibilities when these services were being provided. But the RP on the day of the inspection had not been fully briefed on all the services provided at the sites. The RP's main role at the registered premises was clinically checking prescriptions, overarching CD management and supporting the ACT with the accuracy checking of prescriptions when needed. The senior pharmacist worked closely with the experienced pharmacy technician who managed the team of pharmacy technicians and dispensers.

Many team members who were in temporary positions had been offered and accepted permanent posts. But a few teams faced staffing challenges, mainly the goods-in team, which had some impact on the medicines receipt process as seen by some backlog of medicines awaiting processing. Senior managers were aware of the challenges and a recruitment strategy was in place. The pharmacy provided specific dispenser training to help team members understand their role in the accurate picking and processing of prescriptions. Other team members did not hold a pharmacy qualification but were suitably trained for their roles and the tasks they performed. These teams had a clear management and coaching structure and team members knew their roles and tasks. They worked systematically and efficiently at their allocated stations and within their teams.

The pharmacy's internal communication systems ensured team members across both sites could effectively respond to colleagues' queries. For example, the pharmacists had a generic email box for all teams to use which was regularly checked. Senior team managers frequently visited both sites so there was regular contact and support for all the teams. Members of the customer service team visited the registered premises to see prescriptions being processed including the dispensing of medicines into multi-compartment compliance packs. This helped them understand the processes involved with the dispensing of prescriptions when responding to people's queries.

The pharmacy provided a structured training and induction programme for new team members. And they were allocated work suitable for their knowledge and experience so they could learn and develop before moving to other areas of the pharmacy operations. Line managers regularly met with trainees to monitor their progression and offer extra support when needed. The pharmacy's coaching team provided one-to-one training at the workstations and used the CCTV at the workstations to observe team members performance. Following a management restructuring programme additional coaching and shift managers roles had been created to support the teams. This had reportedly helped the teams with the accuracy of their workload. All team members had access to ongoing e-learning training, and they had protected time at work to do the training. Line managers monitored team members' completion of the e-learning modules so support could be given when required. The pharmacy also issued a newsletter to provide the teams with up-to-date information.

The pharmacy provided team members with feedback on their performance through informal one-to-one sessions and a formal performance development review (PDR) process. So, they could identify and discuss their development needs. These discussions were recorded for the team member to refer to. Team members' success with meeting personal objectives was actively celebrated. And they were encouraged to work in a culture of openness through the sharing of errors. They were supported to develop their knowledge and skills through opportunities to work in other teams and to take on new roles and responsibilities. One of the experienced dispensers was recruited into the role of supporting the team managing the compliance packs and liaising with other teams especially the customer service team. An ACT who'd wanted to develop their coaching skills was the mentor for trainee dispensers and trainee ACDAs.

Individual teams including the prescribers regularly met and they kept records of the discussions held. All team members were invited to attend and were encouraged to contribute to discussions through shared experience, learning and suggestions for changes. The pharmacists at both sites often met to share learning and keep their knowledge up to date. They used remote meeting technology for their meetings so colleagues working from home could attend. And this forum enabled all team members to keep in touch outside of the meetings by sending messages, sharing learning and asking questions. The senior pharmacist used this technology to send updates outside of these meetings to the pharmacists working from home. The SI and clinical team held regular meetings with the prescribers to discuss treatments and any prescribing incidents. Some were held virtually and every quarter a face-to-face meeting was held. The SI and deputy SI held meetings with the teams at the associated premises to discuss matters including feedback from people using the service and reported incidents.

The pharmacy had a whistleblowing procedure and team members received whistleblowing training. Team members were comfortable raising concerns with their line manager and the SI when necessary. They were invited to provide feedback using annual surveys which they had protected time to complete. The outcome from the surveys was presented to all team members. And used by the senior management to team make appropriate changes such as developing senior roles in the customer service team.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are large and appropriate for the services provided. And the pharmacy is suitably clean, hygienic, and secure. The pharmacy's website is clearly laid out, professional in appearance which helps ensure people accessing the online prescribing service receive appropriate care.

Inspector's evidence

People couldn't directly access the registered pharmacy premises which were in a large warehouse facility that provided plenty of workspace for team members and storage for stock. The pharmacy had separate office space, including for the RP, to ensure privacy and an appropriate environment for the work completed. It used automation and technology for most of the assembly of prescriptions. And there were separate areas with different teams working on different parts of the assembly process. The teams kept the working areas clean and tidy, and they mostly kept floor spaces clear to reduce the risk of trip hazards. There were appropriate health and safety processes for the size and type of premises. The pharmacy had sufficient staff facilities for the number of team members. It had separate sinks for the preparation of medicines and hand washing with hot and cold water available.

The pharmacy's website provided people with information on the services offered, the operating hours, and contact details for the pharmacy. It had a section to "Meet the Team" which included details of the Superintendent Pharmacist (SI), senior pharmacist and the two prescribers for the online doctor service. The website also provided people with information about the private online doctor service including its CQC registration. The website made it clear that the decision about medical treatments was for both the prescriber and the person to jointly consider and the final decision was that of the prescriber. The pharmacy had systems installed to secure the premises and it had an intercom to manage visitors' access to the premises. The pharmacy had clearly marked fire exits.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services to many people throughout the UK and it generally manages these services well. It uses some automation to support the safe delivery of its dispensing service. It regularly reviews its systems and processes and suitably acts to ensure the delivery of its services remain safe and efficient. 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 when they identify stock issues, the pharmacy doesn't always adequately inform people of delays to the receipt of their medicines.

Inspector's evidence

People accessed information for both the NHS and private services on the pharmacy's website. This included 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. And there was a dedicated section providing answers to frequently asked questions. The pharmacy provided the seasonal flu vaccination service at several associated premises managed by dedicated teams. Risk assessments were in place and were reviewed by a senior team member. There were appropriate governance arrangements in place between the teams and the deputy SI who provided updated information and guidance when required. The RP at the registered premises did not have an integral role with these services but was given some details of the services to help keep them, as the RP, informed.

Most people registered to use the NHS and private services via the pharmacy's website. A dedicated registration team managed this process for both the NHS and private services. They highlighted people with similar names, so all teams were alert to this when processing prescriptions. Usually, the registration team asked people how much medication they had left, to ensure they had enough until the first supply was made. The registration team used information from people's prescriptions such as their 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 they'd intended to nominate the pharmacy for their prescriptions. And to discuss any support they needed such as having their medication supplied in multi-compartment compliance packs. The registration team updated the person's account with this information, so all team members were aware. People were signposted to other pharmacies if they needed additional support the pharmacy could not provide.

People accessed the private online doctor service via the pharmacy's website which provided people with information on specific conditions and on the different available treatments. This included treatment for weight loss. People accessing the service completed a consultation questionnaire and were asked to provide consent for their NHS GP to be informed. Video links to complete consultations were an option, but at the time of the inspection they'd not been used. The prescribers provided people with advice about their medical condition and the medication by email and telephone. They reviewed the completed consultation questionnaires with reference to national guidance and internal guidelines, including the pharmacy's repeat prescribing and treatment policy. These guidelines were designed, reviewed, and updated with input from the pharmacists. The prescribers had recently been granted access to people's NHS summary care records (SCR), to allow for

an independent check on information submitted in the questionnaires. A SOP for the use of SCR was in development.

There were additional controls for some treatments due to increased risks and requirements for ongoing monitoring. And supplies of medicines such as propranolol for treating situational anxiety were limited to a maximum number of requests. Several checks and audits were used by the prescribers, the pharmacists and senior team members to ensure medicines were safely and appropriately prescribed. This included monitoring for repeat requests from people for the same medication and checking previous supplies for ongoing treatments. The SI, prescribers and clinical pharmacist team had recently reviewed the prescribing of propranolol for situational anxiety. This resulted in a change to the quantity and strength prescribed to further control its prescribing and supply. And repeat prescriptions for propranolol for situational anxiety were not provided. Specific weight loss treatment guidelines were in place for orlistat, Saxenda and Mysimba. The pharmacists checked the record for repeat supplies of Saxenda which were mostly at monthly intervals, to help ensure the supplies were appropriate.

Each prescriber had a unique login which enabled prescriptions to be generated electronically and prevented their signatures from being modified. Information such as the person's treatment plans was captured on the prescribing system. Whilst this information was not visible to the pharmacists completing the clinical checks, they could see people's answers from the online consultations. The pharmacists emailed the prescribers with queries and kept a record of their contact with them.

The pharmacy dispensed a large number of NHS prescriptions. It prompted people to order these prescriptions and provided a list of their medicines to select from. It reminded people to order their prescriptions early when a bank holiday was due. And it usually checked whether the person had ordered their prescription so a reminder could be sent. The pharmacy requested some people's prescription on their behalf and generally started the process 10 working days before the supply was due. People were given instructions on how to order their prescriptions and were encouraged to use the website or other online platforms. So, the telephone lines were kept free for other enquiries. The pharmacy received most NHS prescriptions electronically and mostly informed people of delays with the receipt of their prescriptions. Or when items had not been prescribed. So, the person was aware and could decide to wait or ask for the prescription to be sent elsewhere. The pharmacy usually asked people if they had enough medication and generally kept a record of this contact with people along with any advice given. When a person wasn't informed of the delays, and this resulted in a complaint, the pharmacy investigated and provided further training to the team members involved.

Any medicines the person advised they didn't need were highlighted so the pharmacists and dispensing team were aware when dispensing the prescription. The pharmacists completing the clinical checks accessed the pharmacy's electronic records and, with the person's consent, their SCR to ensure they had up-to-date information. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). But team members such as the ACTs and ACDAs were not aware if the system highlighted people in the at-risk group. The pharmacists had a rota to ensure the timely completion of tasks such as the clinical checks. The senior pharmacist used information from several dashboards to monitor the team's workload. So, they could reallocate tasks when required. Since the last inspection the responsibility for emailing queries to GP teams had changed to the pharmacists. This was to make the process more efficient and so queries were answered in good time and supplies of medicines not delayed. This change was under review, but the team reported it worked well and provided a more streamlined approach.

The dispensers checked the system for specific dose instructions from the pharmacists when generating the labels to ensure the correct information was included. And they highlighted on the pharmacy's system details such as the person's preferred brand of medication. An ACT checked the accuracy of the

labels before the prescription was released to the next stage in the dispensing process. The labelling process also identified if there was sufficient stock to complete the prescription. When the medicine was unavailable the pharmacists were asked if there was an alternative. If required an owing was generated on the system and the person was usually informed their medication was not available via an automated email. The customer service team generally checked for a response from the person so a reminder email could be sent. 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. A dedicated 'where's my order' team managed out-of-stock items and liaised with colleagues in other teams. So, the pharmacy could prioritise incomplete prescriptions when the stock arrived.

A bar code unique for each prescription was generated and scanned when each stage was completed. And an electronic audit trail identified the team member involved in the different stages of dispensing and checking the prescription. Many of the prescribed items were picked from an automated system but items such as liquids were stored in dedicated areas for manual picking. The manual process consisted of team members scanning bar codes to ensure the correct product was selected. Or using a pick-by-light system that indicated the section holding the product to be picked. Following picking the dispensers completing the process used the bar code to match the prescription with the item picked and the dispensing label. Prescriptions were checked by the ACTs and ACDA's. The ACTs checked all CD prescriptions. And they were monitored throughout the dispensing process to ensure the prescription remained within the 28-day legal limit.

A team packing the completed prescription orders ready for dispatch used the bar code system to ensure the correct number of dispensed items were present. And to match the person's name and address with the dispatch label. The system alerted the team to prescriptions containing a CD or fridge line to ensure they were collected from the specific storage areas. The pharmacy's website provided people with information on how their medication would be delivered and how to track their delivery. Discreet packaging was used for sending people's medication via a UK-wide postal delivery company. The pharmacy upgraded deliveries from a 48-hour delivery to 24-hour delivery if an urgent supply was needed. The pharmacy reviewed and monitored delivery performance to ensure it met the service levels agreed. And it had worked closely with them to understand when industrial action was planned, to minimise the risk of timeliness of deliveries. 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 person was asked to update the pharmacy if their circumstances changed so this 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 which was recorded on the person's account. The pharmacy usually contacted the person when there was a failed delivery and the medicines were returned to the pharmacy and investigated why the medication was returned. This was used to analyse any trends and for the teams to refer to when handling people's queries.

The pharmacy provided many people with their medication in multi-compartment compliance packs and had seen an increase in the number of people requiring this service. A dedicated team of dispensers and ACTs supported the service and worked in a defined area of the pharmacy. The prescriptions were usually requested from the GP seven days before supply to allow time to deal with issues such as missing items. The team referred to a chart listing the person's current medication and dose times when dispensing and checking the medication in the packs. And a record was kept when the packs were completed and ready for dispatch. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the

medicines in the packs and had information about their medicines. Prescriptions which had medicines supplied both in the packs and separately were released together when the packs were ready.

The pharmacy obtained its medicinal stock from several reputable sources. The team reported ongoing issues with the availability of many medicines which were monitored by the pharmacy's purchasing team. This team generated a daily report on stock shortages to share with other teams so they were aware and could take appropriate action. Unlicensed medication received at the pharmacy was assigned a code to ensure it could be tracked once it was entered into the pharmacy's system. One of the ACTs checked the assigned code and the product alongside the information on the pharmacy's system to ensure they all matched. Authorised members of the pharmacy team could accept CDs from the wholesaler on behalf of the RP who remained accountable for the receipt and storage of the CDs. A record of who had received the CDs was kept in case queries arose.

The pharmacy had procedures and systems to safely store and manage its medicines and medical devices to ensure they were fit for purpose. This included checking the dates of stock received from the wholesalers to identify any short-dated stock. The automated picking systems captured the expiry dates of products to reduce the risk of short-dated stock being selected. And the dispensers checked the expiry dates on medicines to see if the dose and quantity prescribed would be within the expiry date of the product. The team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines remained safe to use. When they split the original manufacturer's pack to fulfil a prescription a bar code was attached before returning it to the automated picking section or placing it on dedicated shelves. This enabled the pharmacy's system to identify these packs and to prompt the team to use these packs first.

The pharmacy regularly monitored and recorded the fridge temperatures. And appropriate action was taken when the temperatures went outside the accepted range. The pharmacy stored CDs in cabinets that met legal requirements. And it used appropriate denaturing kits for CD waste which was usually managed by the RP or a senior pharmacist. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. And it took appropriate action in response to the alert.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has a range of equipment that is well maintained to help ensure the safe and effective supply of medicines to people. And its systems suitably protect people's private information.

Inspector's evidence

The pharmacy used automated technology for picking most of the prescribed items. A dedicated team replenished the stock and monitored the performance of the technology using CCTV images and computer data. Two large, open-fronted fridges were connected to an alarm that was triggered by temperatures outside the accepted range. Team members on call were alerted to the alarm when it was triggered outside of the normal operating hours. A back-up generator provided 24 hours of electricity in the event of a power shortage and was regularly tested to ensure it would operate when called upon. The pharmacy had several smaller fridges providing additional storage facilities. The teams used specific storage bags for holding fridge lines throughout the processing of prescriptions to ensure the medicines remained at the correct temperature. Specialised packaging was used for delivering fridge lines to people to make sure the medicine remained at the correct temperature. The viability of the packaging was checked to make sure it maintained the correct temperatures. Team members wore disposable gloves when dispensing medication into multi-compartment compliance packs which were changed after dispensing cytotoxic medicines into the packs.

The pharmacy computers were password protected and data was encrypted to ensure people's confidential information was protected. The data was stored in a cloud-based system which was regularly backed-up and IT support was available 24 hours a day, seven days a week. Some team members worked from home and were given equipment such as headsets to ensure people's confidential information was protected. The pharmacy had systems in place to support team members health and safety at work including a policy and information for team members to refer to. There were 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.