

Registered pharmacy inspection report

Pharmacy Name: Touchwood Pharmacy, 199 Upper College Ride,
Camberley, Surrey, GU15 4HE

Pharmacy reference: 9010288

Type of pharmacy: Community

Date of inspection: 30/09/2021

Pharmacy context

This is an NHS community pharmacy set next to a convenience store in a residential area of Camberley. The pharmacy opens six days a week. It sells a small range of health and beauty products, including over-the-counter medicines. It dispenses people's prescriptions. And people can collect coronavirus (COVID-19) home-testing kits from its premises. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. And it delivers medicines to people who can't attend its premises in person. The pharmacy provides winter influenza (flu) and travel vaccinations. It offers a needle exchange service and dispenses substance misuse treatments. And it can supply a range of medicines to people in person without a prescription, such as the morning-after pill and men's health treatments, through its paid-for patient group directions (PGDs). The pharmacy also supplies prescription medicines to people living in the United Kingdom (UK) or overseas through the company's website, www.pharmacyplanet.com. And pharmacist independent prescribers (PIPs) prescribe these medicines at a distance for a range of long-term conditions, such as asthma, diabetes, high blood pressure and high cholesterol. They also prescribe travel medicines and treatments for weight loss, men's health, women's health and sexual health. This inspection took place during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 doesn't adequately identify and manage the risks associated with its prescribing service. And it doesn't have all the procedures it needs to help make sure its prescribers are working safely.
		1.2	Standard not met	The pharmacy doesn't carry out audits of its prescribing service. And it can't show how it consistently reviews and monitors the safety and quality of its prescribing service.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website allows people to choose a prescription-only medicine (POM) before beginning a consultation with a prescriber.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy doesn't always provide its prescribing service safely. And its prescribing policies don't help its prescribers deliver a consistent prescribing service in line with relevant clinical guidelines. So, people using this service could be put at risk.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy doesn't adequately identify and manage the risks associated with its prescribing service. And it doesn't have all the procedures it needs to help make sure its prescribers are working safely. The pharmacy doesn't carry out audits of its prescribing service. And it can't show how it consistently reviews and monitors the safety and quality of its prescribing service. The pharmacy mostly keeps the records it needs to by law. And it has insurance to protect people if things do go wrong. But some of its records for the prescribing service aren't stored in one place. And this could make it more difficult for its prescribers to decide if a medicine is appropriate to prescribe. People using the pharmacy can provide feedback to help improve its services. Members of the pharmacy team review the dispensing mistakes they make and learn from them to try and stop them happening again. They can explain what they do, what they're responsible for and when they might seek help. They generally know how to protect vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had electronic standard operating procedures (SOPs) and a business continuity plan in place for the services it provided. And these were reviewed centrally by the pharmacy's head office. Members of the pharmacy team were required to read and follow the SOPs relevant to their roles. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. The pharmacy needed to complete occupational COVID-19 risk assessments for its team members. And it needed to report any work-related infections to the appropriate authority. Members of the pharmacy team were self-testing for COVID-19 twice weekly. And they wore fluid resistant face masks to help reduce the risks associated with the virus.

The pharmacy had a document to categorise the risks of the medicines prescribed through its website. But this didn't assess all the risks associated with the pharmacy's prescribing service and how these were mitigated to prevent things going wrong. And, for example, the risks associated with people not providing their consent to contact their General Practitioner (GP) for medication that required on-going monitoring and follow up hadn't been fully considered. This meant that there was a risk that appropriate monitoring or follow up may not be carried out by a GP for people whose condition required it.

The pharmacy's prescribing service used the risk of a medicine being misused and the risks associated with the condition to help categorise medicines into low, average and above-average risk. But the risk document wasn't always followed in practice. And, for example, the risk document categorised medicines that required oversight from a person's GP as "average risk". But some medicines, such as inhalers routinely used for asthma, were categorised as "low risk" medicines despite people with asthma requiring on-going monitoring. And, according to the risk document, these medicines should have been categorised as average risk. The pharmacy also categorised misoprostol, a drug that can be used for treatment of ulcers, as average risk. But misoprostol can be abused and misused to help terminate pregnancies. And, according to the risk document, it should have been categorised as "high risk". The risk document explained that the pharmacy didn't supply medicines with a small therapeutic window too. But examples of regular theophylline prescribing were seen. And theophylline has a narrow therapeutic index, which means there is a small difference between the medicine being therapeutic for a person and the medicine being toxic. Medicines of narrow therapeutic index often

require close monitoring. And there was no evidence to suggest that the GP had been contacted to inform them of any follow-up requirements. The pharmacy's prescribing policy didn't include information on clinical processes, pathways or national guidance that the PIPs needed to follow when providing a prescribing service. Neither the pharmacy's prescribing policy nor the risk document gave an indication of the maximum quantities of medicines the PIPs should prescribe to patients.

The team members responsible for making up people's prescriptions highlighted the locations of some look-alike and sound-alike drugs in the dispensary to reduce the chances of them picking the wrong product. They tried to keep the dispensing workstations tidy. They used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes. They discussed and reviewed them periodically with their colleagues to learn from them and to try to stop them happening again. And, for example, they reviewed their dispensing process following recent mistakes when the wrong formulation of medication was selected.

The pharmacy's prescribing policy required any communication between a patient and the prescriber to be logged and this included information about if a supply was or wasn't made. But the policy didn't provide any direction or detail on what needed to be recorded. One of the pharmacy directors was considering developing a template to support standardised recording of consultations. And this could be used to help assess a prescriber's competency and identify any red flags from the consultation. The policy mentioned the need for an annual clinical audit of the prescribing service to ensure consistency of the service. But no documented evidence of such an audit or appraisals for the prescribers were seen. And the pharmacy team, including the RP, hadn't carried out a review of the prescribing service. The prescriptions were meant to be reviewed daily. But these nor any learnings from the reviews were documented. This meant that the safety and quality of the prescribing service wasn't being appropriately monitored.

The pharmacy displayed a notice that told people who the RP was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were mostly described within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. People sometimes gave feedback about the pharmacy and its team online. And concerns about the pharmacy's prescribing service mainly involved delays in people receiving their medicines. The pharmacy didn't make it clear on its website how people could give feedback and raise concerns about its prescribing service. But the pharmacy displayed a notice next to its counter asking people for their views and suggestions on how it could do things better. And, for example, it tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy and its prescribers had insurance arrangements in place, including professional indemnity, for the services they provided. The pharmacy kept clinical records for its prescribing service. And these included the completed questionnaire, what treatment was initiated and where they had requested further information from patients such as proof of monitoring, follow up and proof of diagnosis. The prescribers needed to document the reasons for refusing treatments. And any communication with a person's GP was stored too. However, the clinical records were fragmented and weren't stored in one place. This could make it difficult for another prescriber to review the records of a

previous consultation to help aid their clinical decision making. Prescriptions were generated electronically once the prescriber decided to prescribe a medicine. But the process wasn't robust enough and the risks associated with it hadn't been fully identified and managed. This was because members of the prescribing service team could log onto the system and generate a prescription and the prescribers could generate prescriptions for one another. Once authorised a prescription was sent to the pharmacy using Microsoft Teams. But the consultation records and the completed questionnaire weren't shared with the pharmacy team. This limited the RP's ability to assess the clinical appropriateness of what had been prescribed. The pharmacy kept a record to show which pharmacist was the RP and when. And these were generally in order. The pharmacy had a controlled drug (CD) register. But the address from whom a CD was received from wasn't always recorded in it. And sometimes correctional notes were undated. The pharmacy team was required to check the stock levels recorded in the CD register at regular intervals. The pharmacy kept records for the supplies of unlicensed medicinal products it made. But it didn't always record when it received one of these products. The pharmacy recorded the emergency supplies it made electronically. And these generally were in order. The pharmacy recorded the private prescriptions it supplied electronically too. But the prescriber's details for supplies of prescription-medicines made online were often incorrectly recorded. And the pharmacy kept concurrent private prescription registers.

The pharmacy had an information governance policy in place. It displayed a notice that told people how their personal information was gathered, used, and shared by the pharmacy and its team. And its team members needed to agree that they would keep people's private information safe. People using the pharmacy couldn't see any other people's personal information. The pharmacy had arrangements to make sure its confidential waste was collected and then sent to a centralised point for secure destruction. But people's details weren't always obliterated or removed from the unwanted medicines returned to the pharmacy before being disposed of. The pharmacy had safeguarding procedures. And the RP had completed a level 2 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And they had the contacts they needed if they wanted to raise a safeguarding concern. The prescribing service's prescribers didn't initiate medications for undiagnosed conditions. There was evidence that medicines had been prescribed to people for gender dysphoria. But the regular prescriber explained that they didn't initiate any medicines for gender dysphoria. And they expected to see letters from consultants working at gender clinics. The prescribers couldn't show any evidence of training or competence for this area of treatment. But one of them was enrolled on a course by the Royal College of General Practitioners.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team mostly do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy had seven team members who provided face-to-face services. This included the RP, some dispensing assistants, trainee dispensing assistants and a delivery driver. The prescribers and the prescribing service's support team weren't based at the pharmacy premises. The RP managed the pharmacy and its team. The RP was supported by three team members at the time of the inspection. The pharmacy relied upon its team, team members from one of the company's other pharmacies and locum pharmacists to cover team members who were absent. Members of the pharmacy team worked well together and supported each other. So, they could process people's prescriptions and requests safely. Some pharmacy team members had recently started at the pharmacy. And they needed to undertake accredited training relevant to their roles after completing a probationary period. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. One of the team members described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to a pharmacist. Members of the pharmacy team discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete training to make sure their knowledge was up to date. And they could train while they were at work. But they were sometimes too busy dealing with people or helping manage the pharmacy's workload to do so.

The prescribing service was provided remotely by a PIP who currently worked in general practice. They were supported by the superintendent pharmacist, who was also a prescriber, and a small team based at the pharmacy's head office. A third PIP, who also worked in general practice, provided guidance and support to the prescribers. But they didn't currently prescribe any medicines for the pharmacy's prescribing service. The prescribers could discuss prescribing decisions with one another. But they occasionally relied upon their general practice colleagues to support their prescribing decisions. There were contingency arrangements in place for the prescribing service and the superintendent pharmacist would support the main prescriber during busy periods, holidays and sickness. The pharmacy shared evidence of the training its PIPs had completed. This included certificates from Centre for Pharmacy Postgraduate Education courses, including contraception, clinical history taking, diabetes and hypertension, and examples of attendance at conferences and webinars such as an antimicrobial resistance conference. The prescribers were required to work within their competence. But the pharmacy could do more to standardise a method of assuring that its prescribers are competent in the treatment areas they prescribe for. And, for example, there were some treatment areas, including sexual health, gastrointestinal disorders and medicines for eyes, nose and throat, where there was no evidence of the prescriber's competence. The prescribers decided to stop prescribing Ozempic, a

medicine used to manage the symptoms of Type 2 diabetes, due to an increase in demand for it. They believed people were using it as a weight-loss drug. And despite making changes to the website informing people that it wouldn't be prescribed if the patient hadn't been previously diagnosed with Type 2 diabetes. This resulted in the medicine being permanently removed from the pharmacy's website. The pharmacy planned to have six-monthly meetings between those involved in the prescribing service. And the minutes of the most recent meeting was shared. But these were brief and provided little details of any discussions. And, for example, a suggestion was made to amend the questionnaire for hormone replacement therapy to include a question about hysterectomies. But the details of what needed to be changed and why weren't documented. The RP rarely raised concerns about the prescribing service before the inspection. But has liaised with the prescribers more since the inspection to make sure concerns, including clinical issues, are raised promptly.

The pharmacy had a whistleblowing policy. It held meetings when it could to update its team and share learning from mistakes or concerns. Members of the pharmacy team sometimes found it challenging to do all the things they were expected to do. But they felt able to make the right decisions to ensure people were kept safe. And their judgement wasn't affected by targets. The prescribers were employed by the pharmacy and there were no targets or incentives for them to prescribe. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to a change to the pharmacy's layout.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy provides an adequate and secure environment to deliver its services from. And people can receive services in private when they need to. But the pharmacy's website allows people to choose a prescription-only medicine before beginning a consultation with a prescriber.

Inspector's evidence

The pharmacy was air-conditioned, bright, secure, and appropriately presented. It had the workbench and storage space it needed for its current workload. But its workbench could become cluttered when it was busy. The pharmacy's website provided some of the information it needed to in line with our guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. But a person could choose a prescription-only medicine before there had been an appropriate consultation with a prescriber. And the website didn't make it clear that decisions about treatment were for both the prescriber and the person to jointly consider during the consultation, but the final decision would be the prescriber's. The website also told people that, in addition to this pharmacy, their orders were fulfilled at another pharmacy when they weren't. The pharmacy had a consulting room for the services it offered. And this could be used if people needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. And it was locked when it wasn't being used. So, its contents were kept secure. The pharmacy had the sinks it needed for the services it delivered. And each sink had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy. But they didn't always get time to do so.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy provides services that people can access. But it doesn't always provide its prescribing service safely. And its prescribing policies don't help its prescribers deliver a consistent prescribing service in line with relevant clinical guidelines. So, people using this service could be put at risk. The pharmacy offers flu vaccinations and keeps records to show that it has given the right vaccine to the right person. And its team is helpful. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team broadly carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy team disposes of most people's unwanted medicines properly too.

Inspector's evidence

The pharmacy had a ramp leading to its entrance. And this helped people who had trouble climbing stairs, such as someone who used a wheelchair, enter the building. The pharmacy had a notice that told people when it was open. And it advertised some of its services in-store. The pharmacy had a small seating area for people to use when they wanted to wait. This was set away from the counter to help people keep apart. Members of the pharmacy team were helpful. And they signposted people to another provider if a service wasn't available at the pharmacy. The pharmacy offered a local delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person.

People accessed the pharmacy's prescribing service through its website. And if they had questions or concerns about the medicines they ordered, they could raise these via the prescribing service's customer service team. The customer service team would take their details and refer their query to the prescriber. The prescriber would then be able to contact them. One of the directors explained that this usually happened when a person's order was rejected. People could also contact the pharmacy. And, if needed, the pharmacy team could refer requests relating to the prescribing service to the customer service team. The prescribers needed to signpost people to another provider if a medicine was not appropriate for them. And, for example, a request for medication for an underactive thyroid resulted in the person being signposted to an endocrinologist as the results of a blood test they provided didn't show that they required the medicine.

The pharmacy's prescribing service had a system where multiple requests within three months of the same medication were flagged by the customer service team. This wasn't an automated system. Flagged orders weren't automatically rejected. But they required the prescriber to carry out a review and further checks. And they helped identify inappropriate requests. In some cases, the prescriber would contact the patient to find out why they were requesting the medication again. And, additionally, the prescriber was expected to check previous orders to make sure medicines weren't supplied excessively. The prescriber could also reduce the quantity they prescribed too. However, the pharmacy didn't set the maximum quantity that could be prescribed for certain types of medicines. And these weren't built into the pharmacy's risk assessments or prescribing policies. A prescription was seen where an overseas patient had been prescribed four salbutamol inhalers, a short-acting bronchodilator routinely used for people with asthma or chronic obstructive pulmonary disease. These conditions require follow up and monitoring. Another prescription for colchicine, a medicine used to treat flare-ups of gout, was also seen. The prescriber prescribed 36 tablets. This was enough for three courses of

treatments. One of the pharmacy directors explained that people often wanted to keep extra medication when asked about the quantities prescribed in these cases. So, the prescribers were required to exercise their professional judgement when assessing each request before prescribing. But there was a risk of inconsistencies in prescribing between the prescribers and a risk of excessive quantities of medicines being supplied. The prescribing service kept records of the refusal to supply prescription-only medicines which were unsuitable for patients or where there was a lack of information. And, for example, a request for metformin, a medicine used in the management of diabetes, was declined. This was because the person only provided a letter confirming a previous supply from another online prescribing service and not their GP when asked for proof of diagnosis and how their condition was being monitored. Other examples were seen where the prescriber had requested further information or evidence of results and monitoring to support their clinical decision making. And if the patient required additional counselling, advice or safety-netting this was generally done too.

The prescribers were said to follow national prescribing guidance. But the pharmacy's prescribing policy didn't contain any information on clinical pathways, guidelines or procedures that the prescribers needed to follow when prescribing. And medicines that required on-going monitoring and management, and that had a narrow therapeutic index were supplied by the prescribing service. The prescribing policy also required the pharmacy to notify the GP of any treatments prescribed if a patient gave their consent to do so. But many of the online questionnaires seen didn't include a question seeking people's consent for this. So, there wasn't always an appropriate process in place for seeking consent. And only about a third of people gave their consent for the prescribing service to notify their GP of what was prescribed. This meant there was a risk that patients were prescribed medications which required monitoring and weren't appropriately followed up. There was also evidence that overseas patients were prescribed medicines that required on-going monitoring and medicines that had a narrow therapeutic index. But it was unclear if these patients' regular clinicians were notified when a decision was made to prescribe these types of medicines.

The pharmacy's online consultation asked people for their permission to access their Summary Care Records (SCR). And, generally, the prescriber accessed the SCR when consent was given to support their clinical decision making. But SCRs were only available for people in England. And the prescribing service was available to people in the rest of the UK and overseas. The pharmacy's prescribing policy required the prescriber to ascertain the necessary information needed to make an informed decision before a medicine could be supplied overseas. And, for example, this included confirming whether the patient understood English, validating the patient's medication history and obtaining proof of current prescription. But the risks, such as the authenticity of the prescriber and ensuring appropriate follow up contingencies, hadn't been fully considered. This meant there was a risk that people outside of England, including overseas patients, could obtain, or continue to take, medicines that weren't suitable for them without oversight of their regular prescriber. The prescribing service used an identity checking system to check people were who they said they were. And when their details couldn't be validated, this was flagged to the prescriber. The prescriber then needed to carry out further checks including asking additional questions and requesting evidence of identity. But these checks weren't always robust enough. And, occasionally, people requested, and were prescribed, medicines on behalf of other people. There were also instances when identity checks weren't carried out for overseas patients. A prescription for an overseas male patient for three items issued through the pharmacy's prescribing service was seen on the day of inspection. The PIP had prescribed Ovestin, tadalafil and sildenafil. The PIP explained that the patient had ordered Ovestin, a medication routinely used to relieve menopausal symptoms in the vagina, for a relative. This was contrary to the pharmacy's position not to prescribe for another person except for EpiPen Junior for a child. The prescriber also confirmed that the patient's identity wasn't verified too. An incident involving the appropriateness of the prescribing and supply of a blood pressure medicine to a person from Scotland was raised with the pharmacy team by a healthcare

professional. The patient had used the medicine inappropriately to try and cause harm. The pharmacy took steps to prevent the patient from trying to obtain further supplies through its website. But the identity checks, proof of diagnosis and checks to see if the medicine had been prescribed previously weren't robust enough. This meant people were able to falsely obtain medicines for themselves or other people.

The pharmacy used Royal Mail's tracked postal service to deliver medicines ordered through the company's website to people living in the UK and overseas. And an online customs declaration was generally completed for deliveries made outside of the UK. The handover of assembled prescriptions to the delivery agent occurred at the pharmacy premises under the supervision of the RP. And an audit trail was generally kept for each postal delivery. The pharmacy used tamper-evident packaging to deliver these prescriptions. It used ice packs and a proprietary brand of insulated packaging when supplying products that needed to be refrigerated. And it had assured itself that this delivery method maintained an appropriate temperature range during the transit of these products from the pharmacy to the delivery address. The pharmacy had a process for dealing with orders returned to it. Its team quarantined any undelivered medicines when it received them. And these medicines weren't reused but were disposed of.

The pharmacy supplied COVID-19 rapid lateral flow tests that people could use at home. This was to help find cases in people who may have no symptoms but are still infectious and can give the virus to others. The pharmacy had the anaphylaxis resources it needed for its vaccination services. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team made sure the sharps bin was kept securely when not in use. The pharmacy had PGDs for its vaccination services and for the supply of some prescription-medicines to treat specific conditions. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be repackaged. It generally provided a brief description of each medicine contained with the compliance packs. But an audit trail of the person who had assembled and checked each compliance pack wasn't always kept. And patient information leaflets weren't always supplied. So, people didn't always have the information they needed about their medicines. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But prescriptions for CDs weren't routinely marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. And some filed CD prescriptions awaiting collection were found to have expired. Members of the pharmacy team knew that valproate mustn't be used in any woman or girl able to have children unless there was a pregnancy prevention programme in place. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the resources it needed for when it dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. And it recorded when it had done these checks. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy generally kept its out-of-date and patient-returned CDs separate from in-date stock. And its team kept a record of the destruction of CDs people returned to it. The pharmacy had procedures for handling the unwanted medicines people returned to it. These medicines were kept separate from stock and were placed in a pharmaceutical waste bin. But some unwanted CD medication

was put into this bin by mistake. And the pharmacy didn't have an appropriate bin for hazardous waste medicines. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had some plastic screens on its counter. It had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a range of glass measures for use with liquids, and some were marked for use only with certain liquids. It had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of this refrigerator. People's personal data was kept securely. And the pharmacy's website used a secure payment system. The pharmacy restricted access to its computers and patient medication record systems. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. Most of the team members responsible for the dispensing process had their own NHS smartcard. And they each made sure their card was stored securely when they weren't working.

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.