

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: 22/02/2023

Pharmacy context

This NHS community pharmacy is set next to a convenience store in a residential area of Camberley. The pharmacy is part of a small chain of pharmacies. It opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy provides a substance misuse treatment service. It supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. It has a travel clinic. Its team can check a person's blood pressure. And people can get their flu vaccination (jab) at the pharmacy. The pharmacy supplies prescription medicines to people living in the United Kingdom (UK) or overseas through the company's website - www.pharmacyplanet.com. 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. And they prescribe treatments for weight loss, men's health, women's health and sexual health. The inspection was undertaken over two days, on 22 February and 27 March 2023.

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	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy cannot show it always completes all the necessary checks before its prescribers issue prescriptions. And it has an inconsistent approach to prescribing meaning there's a risk of variation in prescribing decisions. The pharmacy doesn't always share information with a person's regular doctor or prescriber for medicines which could be misused by vulnerable people. Its prescribers sometimes prescribe weight-loss treatments based on an online questionnaire only. And some of its questionnaires used by people seeking repeat medicines don't adequately rule out illnesses or conditions where a face-to-face assessment would be more appropriate, such as acute urinary retention or a urinary tract infection.
		4.3	Standard not met	The pharmacy sends out medicines which require cold storage to people living in the UK and abroad. But it cannot provide sufficient assurances that the medicines are always kept at the right temperature during transit.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy adequately identifies and manages its risks including those associated with its prescribing service. And it has written instructions to help its team and its prescribers work safely. The pharmacy reviews and monitors its prescribing service. But it doesn't always log the actions it takes following these audits. The pharmacy generally has the records it needs to by law. And it mostly keeps appropriate records for its prescribing service. The pharmacy has insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy review the mistakes they make and learn from them to try and stop the same sort of things happening again. They know what they can and can't do, what they're responsible for and when they would seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had considered the risks of coronavirus (COVID-19). And, as a result, it had put some screens on its counter to try and stop the spread of the virus. People who worked at the pharmacy knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had electronic standard operating procedures (SOPs) for the services it provided. And these were reviewed regularly by a team based at the pharmacy's head office. Members of the pharmacy team were required to read and complete training on the SOPs relevant to their roles to say they understood them and would follow them. The team members responsible for making up people's prescriptions tried to keep the dispensing and checking workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out or dispatched until they were checked by the responsible pharmacist (RP) who also initialled the dispensing label. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team highlighted and separated a few medicines which were similar in some way, such as those that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being selected. They used a mobile phone application to record the mistakes they made. And they usually discussed and reviewed the mistakes they made to learn from them and reduce the chances of them happening again.

The pharmacy had risk assessments for its prescribing service. And they covered the range of conditions for which medicines were prescribed. The risk assessments seen were signed and dated by the author, the clinical lead and the superintendent (SI) pharmacist. And they were overdue for review. But an assurance was given that they would be reviewed following the inspection. The risk assessments included a list of available products which could be prescribed and specified the length of treatment. There was a list of prescribing guidance the prescribers could use. And this included guidance from the National Institute for Health and Care Excellence and the British National Formulary (BNF). The risk assessments outlined the consultation questionnaire for each condition and included a rationale for each question. They also included a list of cautions the prescriber needed to consider for each medication such as antimicrobials and non-steroidal anti-inflammatory drugs. And some medicines had information relating to monitoring requirements such as those used for diabetes and hormone

replacement therapy (HRT). The risk assessments included information for prescribers to consider when treating certain patient groups, such as in pregnancy. They also had links to the BNF or the manufacturer's published information on the medication. Some conditions had details of when referral to the person's GP should be considered such as people with severe pain or people for whom their condition adversely affects their psychological wellbeing, for example, acne rosacea. The risk assessments were available to the prescribers through the communication platform they used to communicate with each other.

The 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. The prescribers didn't offer to prescribe medicines which were deemed as high risk. And these included controlled drugs (CDs), medicines used to treat anxiety and insomnia, medicines with a narrow therapeutic window and medicines which the pharmacy identified were liable to diversion. Routes of administration were also considered when assessing risk. The risk categorisation for each medicine outlined its treatment category, legal classification and risk grading. The PIPs didn't offer to prescribe antimicrobials for acute conditions as it was felt these should be managed during a face-to-face consultation. But antibiotics were sometimes prescribed for conditions affecting sexual health. The prescribers, SI, clinical and operational leads adopted a collaborative approach to risk categorisation. And though there was no defined interval for reviewing the risk categories, a review was generally prompted by regulatory guidance, safety alerts and evidence from practice.

The pharmacy had reviewed its prescribing data on propranolol, nitrofurantoin and trimethoprim. It identified that its prescribers routinely rejected requests for propranolol. This was largely due to the difficulties in confirming prescribing history for people requesting this medicine. And, as a result, the SI decided to discontinue propranolol from the list of medicines available from the pharmacy's prescribing service. The pharmacy identified most requests for nitrofurantoin and trimethoprim were for acute infections. And it had decided that face-to-face consultations, including video consultations in some instances, were needed for acute infection prescribing. So, the prescribing of these antibiotics was paused until a review of the pharmacy's remote prescribing of antimicrobials had been completed. The clinical lead reviewed a sample of prescribing decisions made by each prescriber during one-to-one meetings. These meetings were recorded. They showed the clinical lead confirmed the prescribing rationale with the prescriber and discussed the decision-making process. And they included how the prescriber communicated with the patient and what guidance they used. Though videos of these meetings showed the pharmacy had a process to review and monitor its prescribing service, no documented audits or records of learning outcomes or recommendations were maintained. So, the pharmacy may have missed opportunities to review and strengthen its prescribing service further.

The pharmacy had a notice that told people who the RP was at that time. 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 described within the SOPs. A team member explained that they couldn'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. Some people have shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It displayed a notice next to its counter asking people for their views and suggestions on how it could do things better. And the website associated with the pharmacy's remote prescribing service told people how they could complain or provide feedback. The pharmacy owner changed the layout of the website following feedback from the last inspection.

The pharmacy and its prescribers had insurance arrangements in place, including professional

indemnity, for the services they provided. The pharmacy had an electronic CD register which was in order. And the stock levels recorded in the CD register were checked as often as the SOPs required them to be. The pharmacy usually kept appropriate records for the supplies of the unlicensed medicinal products it made. And it had an electronic record to show which pharmacist was the RP and when. But some recent entries were incomplete. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But occasionally the reason for making a supply of a prescription-only medicine (POM) to a person in an emergency wasn't recorded properly. And the prescriber details or the date of prescribing weren't always complete or correct in the private prescription records. The pharmacy's records showed which prescriber had made notes on each consultation. The consultation records seen covered a range of medicines prescribed by the PIPs. Prescribers usually confirmed with people that they had been prescribed the medicine before. People could upload proof of previous prescribing such as an image of a prescription. And the PIP could confirm a person's prescribing history with their usual prescriber when they had the person's permission to do so. But occasionally this was not the case. And, for example, a weight-loss treatment and salbutamol were prescribed despite no evidence of them being prescribed before being provided to or obtained by the PIP.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had an information governance policy. It displayed a privacy notice instore and a privacy policy was published on its website. And these told people how the company gathered, used and shared their personal information. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of. The pharmacy had safeguarding procedures. The PIPs and the RP had completed level three safeguarding training as they all worked in patient-facing roles. And some PIPS had completed additional training on suicide awareness and mental capacity. 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. The PIPs used their professional judgement to decide if they needed to check the information a person gave them with the person's usual prescriber before prescribing a medicine. And, for some conditions, the prescriber asked people to upload a photograph of themselves to help them decide what to recommend. But the pharmacy could do more to make sure its prescribers made consistent decisions so certain medicines, such as weight-loss treatments, were only prescribed for people for whom they were safe or appropriate for.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough people in its team to deliver its services safely and effectively. Members of the pharmacy team mostly do the right training for their roles. They work well together and make appropriate 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 nine team members who worked at its registered premises and could provide face-to-face services. This included the RP, a pharmacy technician, dispensing assistants, a medicines counter assistant, a trainee medicines counter assistant, a team member who recently started at the pharmacy and a delivery driver. The prescribing service was provided remotely by four PIPs (including the SI). The prescribers and the pharmacy team were supported by a small team based at the pharmacy's head office and a clinical lead. The clinical lead was also a PIP. They worked in general practice, provided general guidance and support to the prescribers. But they didn't currently prescribe any medicines to people through the pharmacy's prescribing service.

The RP managed the pharmacy and its team. The RP was supported by five team members at the time of the inspection. The pharmacy relied upon its team, team members from another branch or locum pharmacists to cover absences. Members of the pharmacy team were up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member 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 and people with long-term health conditions to a pharmacist. The pharmacy had an induction training programme for its team. People who worked at the pharmacy needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. Members of the pharmacy team discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were usually kept up to date during one-to-one discussions or ad hoc team meetings. And they were encouraged to complete training when they could. But they were sometimes too busy to train when they were at work.

The pharmacy tried to make sure one of its prescribers was available during working hours to answer any queries relating to prescriptions issued by its prescribing service. The RP clinically checked each prescription issued through the pharmacy's prescribing service. This meant that prescribing and dispensing checks were separated and completed by different individuals. The prescribers also worked in roles within the NHS where they prescribed regularly. And evidence of their training, which covered a range of aspects from clinical practice, was seen. The prescribers discussed continuing professional development (CPD) opportunities during regular prescribing meetings and with one another. And each prescriber completed peer review sessions with the clinical lead relating to their prescribing. The prescribers were encouraged to use their own professional judgement when prescribing. And they had the autonomy to reject orders they felt were unsafe. The pharmacy used a collaborative approach to

flag people's records if the prescribers or the pharmacy team felt someone was trying to seek medicines inappropriately. The pharmacy team could contact the prescribers to query any prescription they received. And evidence of the pharmacy team's interventions, such as requesting additional information from the prescribers and highlighting duplicate orders, was seen. The prescribers could discuss and seek advice about prescribing decisions with one another. They were encouraged to contribute to the development and review of the prescribing service's risk assessments and the risk categorisation of the medicines they prescribed. They used an electronic messaging platform to create discussion threads which they could all contribute to. And, for example, the SI used this platform to ask the prescribers to complete training on certain CPD modules such as diabetes.

The pharmacy had a whistleblowing policy. The prescribers were employed by the company that owned the pharmacy and there were no targets or incentives for them to prescribe. People who worked at the pharmacy didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They 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 the introduction of a dispensing operations team associated with the pharmacy's prescribing service.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver its services from. Its website meets GPhC guidance. Its premises are clean and secure. And people can receive services in private when they need to.

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. The website associated with the pharmacy provided the information it needed to in line with our guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. And a person couldn't choose a POM before there had been a consultation. The website told people that the pharmacy fulfilled their orders. The pharmacy had a consulting room for the services it offered that required one and if someone needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy cannot show it always completes all the necessary checks before its prescribers issue prescriptions. And it has an inconsistent approach to prescribing meaning there's a risk of variation in prescribing decisions. The pharmacy doesn't always share information with a person's regular doctor or prescriber for medicines which could be misused by vulnerable people. Its prescribers sometimes prescribe weight-loss treatments based on an online questionnaire only. And some of its questionnaires used by people seeking repeat medicines don't adequately rule out illnesses or conditions where a face-to-face assessment would be more appropriate, such as acute urinary retention or a urinary tract infection. The pharmacy sends out medicines which require cold storage to people living in the UK and abroad. But it cannot provide sufficient assurances that the medicines are always kept at the right temperature during transit. However, the pharmacy generally provides its other services safely. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people the information they need with their compliance packs to help them take their medicines safely. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

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 had a television display in one of its windows that told people about some of the services it provided. 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. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local doctor surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and helpful. They usually took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

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 support team by email, telephone or electronic chat. The prescribing support team would take their details and refer their query to one of the prescribers or the pharmacy team if it wasn't an administrative matter. The prescribing service tried to make sure a prescriber was available to answer people's queries. And the prescribers had access to the electronic chat records. And this helped them maintain the continuity of people's care.

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 proof of identity. The prescribers usually asked people who lived in England for their consent to access their

Summary Care Record (SCR) if needed. And for some conditions, such as asthma and diabetes, it was mandatory for the person to provide consent for the PIP to access their SCR. But other medicines, such as those which could be purchased from a pharmacy without a prescription, did not require this. The prescribers generally asked for additional information if SCR access wasn't possible or if the person didn't have a SCR such as those who didn't live in England. The prescribing service didn't allow the prescriber to initiate treatment of several medicines including treatments for asthma, diabetes and an underactive thyroid. And these patients needed to be under the care of a physician and have been prescribed the medication previously before the prescribers would prescribe it. But the pharmacy didn't consistently verify that these conditions were being monitored by another prescriber. And it didn't routinely check that blood tests were completed by someone else. The prescribers could add a flag to a person's record to require evidence of blood tests before future prescribing could occur. The prescribing service didn't require a previous diagnosis or prescription for some other conditions such as eczema and psoriasis, or contraception. The prescribers had autonomy to decide if they issued a prescription. They could seek opinions from other prescribers to help them in their decision-making process if they were unsure. And they sometimes contacted a person's GP surgery for confirmation of medical and prescribing history. But this wasn't a mandatory requirement and was decided on a case-by-case basis. The prescribers didn't consistently check information regarding people's weight and height when prescribing weight-loss medicines. But they sometimes asked people for a full body photograph to help them decide if it was appropriate to prescribe. They routinely rejected requests from people with a low BMI (body mass index). And repeat orders for weight-loss medication usually required the prescriber to confirm the person had lost weight by using the medicine. The prescriber exercised their professional judgement to decide whether they needed to independently verify information provided in an online questionnaire or during a conversation with the person. The prescriber sometimes contacted the person or their regular prescriber to check the information provided. And the person's record was annotated to highlight the discussion for future reference. But this wasn't done consistently, and it often depended on the professional judgement of the prescriber. So, there was potential for variation in prescribing decisions. The prescribers sometimes prescribed weight-loss treatments based on the online questionnaire alone. And the pharmacy couldn't demonstrate that it always protected vulnerable people, such as those with eating disorders or body dysmorphia, seeking these medicines. The prescribing service used some questionnaires to gather information from people that didn't sufficiently exclude differential diagnoses. And, for example, the questionnaire for urinary frequency didn't exclude potential urinary tract infections as a potential cause, and the questionnaire for urinary retention didn't differentiate between a chronic or an acute presentation. The clinical lead and the SI accepted that a review of questionnaires was needed to ensure the questions asked effectively excluded causes which would need referral or alternative treatment.

People were asked for their permission or consent so the pharmacy could notify their regular prescriber before they were prescribed medication by the prescribing service. And, when people did give their consent, the pharmacy sent a letter to their regular prescriber detailing what was prescribed and when it was supplied. But this wasn't mandatory. And over a third of people using the prescribing service in the six months before the inspection didn't consent to the pharmacy sharing information with their prescriber. But the PIPs used their professional judgement to determine if it was safe and appropriate to prescribe without notifying the person's regular prescriber. And sometimes the order was cancelled if they determined it was necessary to notify the regular prescriber and the person didn't provide their consent. So, there was the potential for an inconsistent approach to sharing of information.

Most people in the six months before the inspection used the prescribing service to request medication on a single occasion. And very few people were repeat customers. The pharmacy rejected several requests from people to be prescribed medication for a range of conditions. And reasons for rejecting

these orders included requests for medication that hadn't been prescribed previously, requesting medicines too early, being unable to verify a person was under the care of a physician and medication requests for unlicensed indications. The pharmacy provided examples of communications sent to people when orders were rejected. And these included the reason for rejecting the person's order and signposting the person to their GP or regular prescriber. The PIPs could add flags to records of people using the service based on their history or risk profile as determined by the prescribers. And examples included people who had been unable to provide evidence of identity or medical history, and those for whom the prescribers had concerns about what the medicine would be used for. The prescriber could also use a flag to highlight people for whom an additional consultation was needed to determine the appropriateness of prescribing based on the prescriber's experiences with previous requests. This meant the prescribers were aware of potential safety concerns relating to people using the service.

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 usually kept for each 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 assurances from the manufacturer that the packaging maintained an appropriate temperature range (between 2°C and 8°C) for these products during transit for up to 72 hours. But some people, such as those who lived overseas, didn't receive their medication within this period. In some instances, it took over ten days for the medicine to be delivered. And the pharmacy couldn't always show when a patient had received their medication. The prescribing support team told people that their medication would be dispatched in packaging to help maintain a cold temperature. But the medication's expiry date would be affected if it was in transit for more than 72 hours. So, in these cases, the prescribing support team told people when their medicine would expire in line with its interpretation of the manufacturer's Summary of Product Characteristics. But people could cancel their order if they weren't happy with this. And the pharmacy team accepted these interpretations as being acceptable. The manufacturer of a refrigerated injectable medication the pharmacy supplied provided advice to wholesalers, healthcare professionals (HCPs) and pharmacies that its product must be kept between 2°C and 8°C during storage and shipping. And wholesalers, HCPs and pharmacies cannot use any part of the time it allowed people to keep the product at room temperature when shipping its product. The pharmacy couldn't show that each manufacturer had confirmed their product remained safe for people to use and what their product's revised expiry date would be when the refrigerated products it shipped weren't maintained at the appropriate temperature range. And the pharmacy hadn't conducted studies to show that refrigerated medicines which were in transit for longer than the 72 hours hadn't been frozen or stored above 30°C. The pharmacy had a process for dealing with orders returned to it. The pharmacy team quarantined any undelivered medicines when it received them. And these medicines weren't reused but were disposed of appropriately.

The pharmacy offered a local delivery service to people who couldn't attend its premises in person. And it generally kept an audit trail to show that the right medicine was delivered to the right person. The pharmacy had, until recently, provided a COVID-19 vaccination service. It provided other vaccinations, such as flu jabs, too. The vaccinators administered these vaccinations under the relevant national protocols. And the RP confirmed that a registered healthcare professional completed the stages of the national protocol they needed to. The national protocols afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the appropriate patient group direction (PGD) was used if the vaccination was solely provided by a pharmacist. The pharmacy had the anaphylaxis resources it needed for its vaccination service. Its team made sure the sharps bin was kept

securely when not in use. And the vaccinators were appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy had PGDs for the supply of some POMs to treat specific conditions such as erectile dysfunction. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. Its team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy didn't always keep an audit trail of the people involved in the assembly of each compliance pack. It generally provided a brief description of the medication contained within the compliance packs. But patient information leaflets weren't routinely supplied with people's compliance packs. This meant that people didn't always have the information they needed to help them take their medicines safely. 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 assembled CD prescriptions awaiting collection weren't routinely marked with the date the 28-day legal limit would be reached and some of them had expired. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They generally marked products which were soon to expire. And they checked the expiry dates of medicines as they dispensed them and at regular intervals. But they didn't always record when they had done so. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept its out-of-date CDs and patient-returned CDs separate from its in-date stock. And its team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and what records they made when they received a drug alert.

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 personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. They had access to up-to-date reference sources. And they could contact the National Pharmacy Association to ask for information and guidance. The PIPs had the resources they needed for their roles. They had access to national and local prescribing guidance. And they could ask prescribing support groups for advice.

The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team generally checked and recorded each refrigerator's maximum and minimum temperatures. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used to do this was recently changed. The website associated with the pharmacy used a secure payment system. And the company took steps to keep people's data secure. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy put its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were 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.