General Pharmaceutical Council

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: 12/01/2024

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 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 a few 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. And people can visit the pharmacy to get their coronavirus booster, flu jab or travel vaccination, or have their blood pressure checked. 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 and diabetes. And they prescribe treatments for weight loss, men's health, women's health and sexual health. The inspection was undertaken over two days on 12 and 29 January 2024.

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	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 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 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. And it logs the actions it takes following these audits. The pharmacy generally has the records it needs to by law. And it 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 to 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 keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had some plastic screens on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also 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. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. 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 the RP. The team members responsible for making up people's prescriptions kept the dispensing and checking workstations in both dispensaries 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 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 used a mobile phone application to record the mistakes they made. They discussed and reviewed the mistakes they made to learn from them and help stop the same sort of things happening again. And, for example, they highlighted the locations of some look-alike and sound-alike drugs on the shelves to help reduce the risks of the wrong product being picked.

The pharmacy had risk assessments for its prescribing service. And these covered the range of conditions for which medicines were prescribed. The pharmacy didn't prescribe medicines it defined as 'high risk' such as controlled drugs or medications which could have a 'street value'. And medicines were categorised as either 'low risk', 'average risk' or 'above average risk'. The pharmacy considered the risks associated with each medicine and the condition for which it was prescribed. Its risk matrix didn't require mandatory GP notification or independent verification of a person's self-reported medical history for medicines assessed as low risk. And these medicines were also assessed as 'unlikely

to be abused and least likely to cause harm if used incorrectly'. The risk assessment for asthma and chronic obstructive pulmonary disease required the prescriber to be satisfied that the person they were treating was under the care of a physician and had been prescribed the item before. And the prescriber also needed to be satisfied that the condition was well controlled and there was no significant change in the condition that would warrant further investigation. The risk assessment required people to be asked for their permission to access their Summary Care Record (SCR). It didn't require the prescriber to confirm someone's clinical history using the SCR before prescribing a salbutamol inhaler. But the superintendent (SI) pharmacist and one of the PIPs gave an assurance that SCRs were checked for every order of salbutamol. And if the SCR wasn't available then alternative evidence of a previous prescription was sought. The pharmacy required regular GP reviews for medicines considered as 'average risk'. But the risk assessment only recommended the prescriber checked a person's self-reported medical history using their SCR. And this differed from what the prescribers did in practice as they routinely checked a person's SCR before deciding to prescribe a treatment for a long-term condition such as high blood pressure. So, the pharmacy could do more to make sure its risk assessments for 'low risk' and 'average risk' medicines reflected what its prescribers did in practice. The pharmacy required its prescribers to independently check a person's self-reported medical history using SCRs or other evidence of previous diagnosis and prescribing before they could consider prescribing an 'above average risk' medicine. These medicines, such as insulin, were assessed as potentially dangerous if not used correctly.

The pharmacy audited its prescribing activity twice a year. And consultation records were audited randomly to make sure all prescribers had their prescribing practice reviewed. The pharmacy didn't base its audits on specific conditions or medicines. But it tried to make sure audits were more representative of each prescriber's workload. This meant that the prescribing of those who prescribed more often was audited more frequently. The prescribers discussed the results of prescribing audits at dedicated meetings so, they could share learning. And, for example, they identified a need for training on the use of hormone replacement therapy for menopause. The pharmacy provided example audit records for a range of consultations. These checked the reason for the order, whether the person was under the care of a physician, whether they had been prescribed the medication before, and whether they displayed any signs or symptoms which would warrant further investigation. And the person who audited the consultation provided their written feedback to the prescriber. The pharmacy reviewed its prescribing data. It maintained oversight of the prescribing activity and used this information to help decide what medicines were offered. It identified that its prescribers routinely rejected requests for propranolol. This was largely due to the prescribers not feeling that it was safe to prescribe it for most people who requested it. And, as a result, the pharmacy decided to remove it from its offering.

People have left online reviews about their experiences of using the pharmacy and its services. They could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. The pharmacy had a complaints procedure. And the website associated with the pharmacy's remote prescribing service told people how they could complain or provide feedback. The pharmacy had reviewed and strengthened its process for the delivery of medicines that require refrigeration 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. And the stock levels recorded in the CD register were checked regularly. But the prescriber details were occasionally incorrectly recorded. The pharmacy kept adequate records for the supplies of the unlicensed medicinal products it made. And it had appropriate records to show which pharmacist was the RP and when. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine (POM) to a person in an emergency wasn't always recorded properly. And the details of the prescriber and the date of prescribing were incorrect in some of the private prescription records seen. The RP gave an assurance that these records would be

maintained as they should be. The pharmacy kept appropriate records of patient consultations for its prescribing service. The records included the person's responses to questions, additional information the prescriber received, such as access to SCRs, and the details of the advice the prescriber provided to the person. The prescribers usually confirmed with people that they had been prescribed the medicine before and proof of previous prescribing could be uploaded. People were asked to provide further evidence to help support the prescriber's decision, such as a full-body photograph for weight-loss treatments and blood test results for medicines use to help control blood glucose levels.

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 had arrangements to make sure confidential information was stored and disposed of securely. And its privacy policy was published on its website. This 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. The pharmacy had safeguarding procedures. And 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 RP and the prescribers had completed safeguarding training as they worked in patient-facing roles. And some prescribers had completed additional training on learning difficulties, mental capacity and suicide awareness. The prescribers could review a person's SCR to check if there were concerns about that person's mental health or other possible vulnerabilities. They could contact the person to better understand their needs if they identified a concern. They could discuss cases of concern with the SI, the clinical lead or another PIP. And if a safeguarding concern was identified they would discuss this with the person's GP if possible. The prescribers could use their judgement and decide not to prescribe if they felt it wasn't safe to do so. They could flag a person's record to highlight potential vulnerabilities to other prescribers such as vulnerable people seeking weight-loss treatments who they signposted to their regular GP for support.

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 usually 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 trainee pharmacist, a pharmacy technician, dispensing assistants, a trainee dispensing assistant, a medicines counter assistant (MCA), a trainee MCA and a delivery driver. The prescribing service was provided remotely by five PIPs including the superintendent (SI) pharmacist. The prescribers and the pharmacy team were supported by a small team based at the pharmacy's head office and a clinical lead. The team included a pharmacist who supported weight-loss patients. 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 the RP. 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 team meetings. And they were encouraged to complete training when they could. 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 remote 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 ongoing continuing professional development and training, which covered a range of aspects from clinical practice, was seen. This included asthma, high blood pressure and weight management. The pharmacy did not set a maximum limit on how many prescriptions a prescriber could authorise each day. But it maintained oversight of the process the prescribers followed to determine if it had enough prescribers for the current workload. And prescribers were able to ask for additional support when they felt this was needed. 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 improvements to the way in which interventions for the remote prescribing service were recorded.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it 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 had a consulting room, a counter, a retail area, a kitchenette, a storage area and a toilet. And it had a dispensary for its face-to-face dispensing service and a separate dispensary for its online activity. The pharmacy had the workbench and storage space it needed for its current workload. It was air-conditioned, bright and secure. And its public-facing area was adequately lit and presented. 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. And it listed the prescribers providing the remote prescribing service. The pharmacy had a consulting room for the services it offered that required one or 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. People’s conversations in the consulting room couldn’t be overheard outside of it. The pharmacy had some sinks and a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy usually completes all the necessary checks to deliver its prescribing service safely. It provides services that people can access easily. And its working practices are generally safe and effective. The pharmacy keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. It delivers prescription medicines to people's homes. And it keeps a log to show that it has delivered the right medicine to the right person. The pharmacy gets its medicines from reputable sources. And it largely stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They 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 seating area for people to use when they wanted to wait. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP 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 used a third-party 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 asked people who lived in England for their consent to access their SCR if needed. And for some conditions, such as asthma, diabetes and weight management, it was mandatory for the person to provide consent for the prescriber 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 routinely 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. And medicines prescribed for the management of weight also required the person to upload a full-body photograph to confirm clinical appropriateness along with proof of identity. The prescribing service didn't allow the prescriber to initiate treatment of several medicines including treatments for 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. The pharmacy didn't usually impose maximum quantities for orders. But it did flag people who sought a medicine too frequently such as six or more salbutamol inhalers in a six-month period. One of the prescribers explained that they checked a person's order history to better understand how frequently they tried to order a treatment, and this helped them decide if they should or should not prescribe a medicine.

The pharmacy provided a random sample of consultation records for its prescribing service for a six-month period leading up to the inspection. And, in the sample reviewed, the prescribers confirmed a person's medical history by accessing SCRs or obtaining other evidence from the person ordering the medicine. The questionnaire asked people to provide information on their general health. And it included specific questions about the condition being treated and the requested product. For example, the questionnaire for salbutamol asked when the person's condition was diagnosed and how well it was managed. And it asked them how frequently they needed to use salbutamol and when their condition was reviewed last by a healthcare professional. The pharmacy provided some examples of weight-loss management consultation records. And these all included proof of identity, a full-body photograph and the person's permission for the pharmacy to notify their GP of the supply. People who were prescribed a weight-loss treatment were contacted a month after their order was placed. They were asked to complete a follow-up questionnaire. And if this highlighted any concerns then a telephone consultation was organised with a pharmacist who supported the pharmacy's weight-loss service. The pharmacy didn't operate a subscription service for its weight-loss service. And a full consultation and the steps outlined above needed to be completed before a further supply could be made. The pharmacy supported people with their weight loss journey. It provided them with a brochure on weight management. And it had partnered with another provider to offer advice and guidance to them on nutrition and exercise to help them lose weight. The pharmacy decided to move people who were prescribed an off-label medicine not licensed for weight loss to a licensed product following the recent National Patient Safety Alert (NPSA). The NPSA discouraged the prescribing of products for weight loss when the product wasn't licenced for this use. And, for example, the pharmacy provided an assurance that Ozempic was only prescribed for the management of diabetes and was no longer prescribed for weight loss.

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 prescribing support team sent a letter to their regular prescriber detailing what was prescribed and when it was supplied. But this wasn't mandatory except for people who were prescribed a weight-loss treatment. And they were required to give their permission for the pharmacy to share information with their regular doctor before the prescribers would consider prescribing a weight-loss treatment. Over half of the people using the prescribing service in the six months before the inspection didn't give their permission for the pharmacy to share information with their prescriber. But the prescribers 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 hadn't provided their consent. But the person was signposted accordingly in these circumstances. 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 used a tracked postal service to deliver medicines prescribed through the company's website to people living in the UK within two days. It used a third-party courier's 24-hour tracked delivery service to deliver medicines overseas or medicines that required refrigeration. And a customs declaration was usually 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. The pharmacy kept an audit trail for each delivery. And this usually included a photograph of the

delivered package and the recipient's signature. 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 tested this packaging to make sure it maintained an appropriate temperature range (between 2°C and 8°C) for these products when they were in transit. 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 kept an audit trail to show that the right medicine was delivered to the right person. The pharmacy had, until recently, provided coronavirus boosters. And 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 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 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 an assessment was done to determine if a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a patient information leaflet and a brief description for each medicine contained within a compliance pack were usually provided. 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 to help make sure supplies were made lawfully. 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. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. But, during the inspection, a team member quarantined an opened packet of a blood pressure medicine as it contained stock from different batches and manufactures. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they usually recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. 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. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took and demonstrated what records they made when the

pharmacy received an MHRA medicines recall.

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 three medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly 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.