

# Registered pharmacy inspection report

**Pharmacy Name:** CloudRx, 1 Hawthorn Park, Coal Road, Leeds, West Yorkshire, LS14 1PQ

**Pharmacy reference:** 9011284

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 25/08/2021

## Pharmacy context

This pharmacy is an internet pharmacy and access to the premises is closed to the public. The pharmacy provides a prescribing platform for private prescribers to generate electronic private prescriptions following a consultation with a person. The pharmacy team contacts people directly following receipt of the prescription. And the pharmacy delivers medicines to people's homes. Prescribers mainly access the pharmacy's website, but people can access it to find out the pharmacy's telephone and email contact details. The pharmacy was inspected during the COVID-19 pandemic.

## Overall inspection outcome

### Standards not all met

**Required Action:** Improvement Action Plan

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards not all met	1.1	Standard not met	The pharmacy doesn't identify and manage all the risks when providing its services working with private prescribers. It especially doesn't fully assess the risks from online prescribers and those prescribers who are not registered in the UK
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards not all met	4.2	Standard not met	The pharmacy doesn't have all the adequate safeguards in place to monitor the supplies of medicines prescribed, particularly from online prescribers. It doesn't complete regular audits to identify repeat supplies. It doesn't check whether prescriber's systems are robust. This may mean some vulnerable people receive medicines that are not suitable for them.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance Standards not all met

### Summary findings

The pharmacy doesn't identify and manage all the risks associated with its services. It has up-to-date written procedures that the pharmacy team follows. But it doesn't assess the risks across all prescribing settings, including online, to ensure the prescribers are practicing safely. The pharmacy mostly completes all the records it needs to by law. The pharmacy team members respond well when errors occur. They complete regular reviews of the errors made and they take suitable action to prevent future mistakes.

### Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. It had some infection control measures in place and it had Personal Protective Equipment (PPE) available. Team members were not wearing PPE at the start of the inspection as they felt it was unnecessary as they weren't in direct contact with the public and the pharmacy was large and airy. They all donned the PPE masks when requested by the inspector. The pharmacy displayed posters regarding social distancing requirements and effective hand washing techniques. And there was hand sanitiser available. In addition to the team members only the delivery drivers from the wholesalers and couriers entered the pharmacy. This meant contact with people other than colleagues from the team was kept to a minimum.

The pharmacy provided a platform for private prescribers to generate electronic prescriptions. The pharmacy had overall control of the running of the platform. Prescribers wishing to use the service registered with the pharmacy before gaining access to the platform and generating private prescriptions. Most of the prescribers worked for clinics, including those providing menopause and slimming treatments. All the prescribers working in the clinics were separately registered with the pharmacy.

The pharmacy team stated during the inspection that prescribers were registered with the General Medical Council (GMC). Apart from a couple of nurse prescribers and a pharmacist prescriber who were registered with the appropriate UK regulator. But data provided by the Superintendent Pharmacist (SI) after the inspection showed one prescriber who was registered overseas, not with a UK regulator. This prescriber, as part of an online prescribing service, used questionnaires to gather medical information about a person, rather than a personal interaction. It was difficult for the pharmacy to ensure the prescriber was working within the regulatory controls put in place within the UK to ensure the safety of people using online prescribing services. The pharmacy had not completed a risk assessment linked to supplying medicines against prescriptions issued by prescribers who were not registered in the UK. The SI had worked with this prescriber over several years and explained the pharmacy had consistently asked for and received the prescriber's licensing and credentials. And had checked they were registered in their home country to ensure they could lawfully issue prescriptions. The pharmacy had also completed identity checks and checked the prescriber had appropriate insurance. The SI explained the online prescribing platform the prescriber worked for was an EU online doctor platform. But the prescriptions the pharmacy received were only for people in the UK. The SI explained, as with all prescribers registering to use the pharmacy's prescribing platform, this prescriber was informed of the pharmacy's procedures and clinical guidelines. And the pharmacy had occasionally contacted the prescriber to query individual prescribing decisions. The SI informed the inspector after the inspection that the pharmacy no longer accepted prescriptions from this prescriber.

The pharmacy had completed risk assessments (RAs) covering the provision of the service but had not completed separate RAs for the different prescribing settings, such as online prescribing. And this was not covered in the pharmacy's dispensing standard operating procedure (SOP). Some private prescribers issued their prescriptions through an online prescribing service where the person accessing the medicines completed an online questionnaire. The pharmacy was aware of this but it had not documented the risks associated with this prescribing setting, in a risk assessment. And the pharmacy did not have sight of the prescribing policies or the completed questionnaires. So, the pharmacy team wouldn't know if the prescribers were working to their own prescribing policies or within UK prescribing guidelines. The pharmacy hadn't completed audits to confirm the online prescribers including those from outside the UK were adhering to the pharmacy's procedures or clinical guidelines.

Some risks the pharmacy had identified in their RA included potential issues with the delivery of medicines to people. The RAs detailed the actions taken to address the identified risks. These included ensuring the pharmacy team always informed the person by text or email when their medication was dispatched so they knew it was due.

The pharmacy had a risk register for the different therapies the prescribers provided treatment for. The register identified common issues such as the person not taking the medication correctly or the risk that the person may abuse the prescribed medication. There were also specific areas of risk related to a treatment programme. The register recorded the actions taken by the pharmacy to mitigate the risks. The actions listed included monitoring the frequency of prescribing of medication identified as being liable to abuse. But the register didn't define what was meant by low level abuse. Or recognise that medication such as antibiotics were at risk of being misused or prescribed outside of UK guidelines. With specific risks the register stated all prescribers registered with the pharmacy had patient identification systems in place and had to meet the standards set by the Care Quality Commission (CQC) for safe prescribing. However, the risk register didn't detail how the risks would be mitigated for prescribers working in clinics outside of the UK who wouldn't be regulated by the CQC or GMC. And therefore, were not required to meet safe prescribing standards set by UK regulators. The data provided by the pharmacy after the inspection showed medicines such as antibiotics and co-codamol were prescribed by the online prescribers based outside the UK. The pharmacy team explained how they would share any concerns about prescribers to the relevant organisations such as the GMC. However, for the prescriber who was not registered in the UK, this would be difficult as they were not regulated by the GMC. The team members had a good understanding of the services provided by the clinics and prescribers but they didn't have access to the prescribers' prescribing policies. Without access to the prescribing policies the team could not check prescribing against the policy or that the policy met clinical guidelines.

As part of the pharmacy's procedures to ensure the safe supply of medication to people the team completed a series of checks prior to registering a prescriber to enable them to access the prescribing platform. The pharmacy checked the prescriber's registration status, obtained passport or driving licence photograph identification and details of their professional indemnity insurance. The team checked for any fitness to practice concerns. And flagged on to the pharmacy's system any restrictions on a prescriber's practice such as medicines the prescriber could not prescribe. The pharmacy reviewed the prescriber's professional registration status and indemnity insurance every six months. This ensured the prescribers the pharmacy worked with remained fit to practise and could legally prescribe. The team also used the information from the record to remind prescribers when their indemnity insurance was due for renewal. The team used social media and other external information sources to see the feedback people gave about the prescribers and the medical treatment they provided. This identified any areas of concern, other than regulatory fitness to practise concerns, that may prevent the prescriber registering with the pharmacy.

The registration process included confirmation from the prescriber that they understood the pharmacy's terms of use which were detailed on its website. Some prescribers and clinics had an account with the pharmacy. The prescriber signed a contract with the pharmacy which included their agreement to meet prescribing standards. And that they had read the pharmacy's terms of use along with the privacy and security policy which were found on its website.

The pharmacy had a range of up-to-date SOPs. These were developed by the SI and showed version control along with the dates of preparation and review. The SOPs provided clear and detailed information to the team to perform the tasks supporting the delivery of pharmacy services. The team had read and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The regular pharmacist audited the SOPs every two months with special attention given to the procedures covering high risk activities. Any discrepancies or non-compliance with the SOPs were investigated. The pharmacist recorded the audit results which included a decision whether another audit was needed. The pharmacy updated the SOPs in response to changes to its services or when new ways of working were introduced. The dispensing SOP was recently updated to include amitriptyline as a medication the team was to monitor the prescribing of. This was in response to concerns raised by team members of an increased number of prescriptions for this medication.

The pharmacy had a procedure for managing errors identified at the accuracy check of the prescription known as near miss errors. The pharmacist recorded near miss errors on a paper log before transferring the details to a spreadsheet. The information captured included details of the error and who in the team was involved. The team members had separated medicines on the shelves that were involved in near miss errors. And the pharmacy had provided them with additional training. For example, one near miss error involved two medicines with similar names. One of the medicines was indicated for females and the other for males. After additional training on these medicines the team members introduced a check of the gender of the person receiving the prescription when selecting the medicine from the shelf. The pharmacy kept records of dispensing incidents that had reached the person. And obtained information from the person such as photographs to ensure the team completed a thorough investigation. The pharmacy captured the details of the dispensing incidents on a separate spreadsheet.

The information from both spreadsheets was shared with the SI and used to generate a monthly report. This included a graph clearly showing common errors and the decline in errors following the actions taken by the team to prevent the reoccurrence of common mistakes. The SI and regular pharmacist had identified an increase in labelling errors which were addressed through discussions with the team and training. The latest graph showed a marked reduction with these errors. The error report was shared with the team at a monthly clinical review meeting that all team members, including the SI, attended. The team members used these meetings to examine errors and any identified trends. And they were encouraged to suggest and agree actions to reduce the risk of similar errors. The meetings were also used to raise awareness amongst the team of new medicines or specialist treatments that the pharmacy had not supplied before. The pharmacy kept the minutes from the meeting for the team to refer to.

The pharmacy had a procedure for handling complaints raised by people receiving the pharmacy services. The pharmacy provided people with information on how to contact the pharmacy team via email or telephone. Or the person could raise their concern through the prescriber. The team escalated the concerns to the pharmacy manager and SI. The SI reviewed the complaints to identify any trends the team should address. A recent review highlighted a small number of complaints were from people who had not wanted the full quantity of medicine prescribed to them. People commented on the

efficiency of having the pharmacy service linked to the clinics they attended as their medication was supplied soon after their appointment.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law were looked at. At the time of the inspection the pharmacy was not displaying the Responsible Pharmacist (RP) notice. After this was highlighted the RP printed off their notice and displayed it. The pharmacy kept the RP record on a spreadsheet but it didn't protect the cells in the spreadsheet. This meant the entries could be amended at a later date or the entry could be lost. The patient medication record (PMR) system had the ability to produce a RP record. But not all the pharmacists when working as the RP logged on to the PMR system. So, this record was incomplete. The pharmacy could not produce the RP record from the PMR system during the inspection and this was reported to the system's supplier. The pharmacy kept an up-to-date electronic controlled drugs (CD) register and the team regularly checked the balance of stock in the register against the physical stock. This helped to spot errors such as missed entries. The pharmacy kept its private prescription records electronically. A sample showed the details captured on the records complied with legal requirements. The pharmacy kept specials records for the unlicensed medicines it ordered and supplied to people. The records were mostly compliant, a few records were missing the prescriber's details.

The pharmacy team was aware of the importance of keeping people's private information secure. The pharmacy had several "Think Privacy" posters displayed to re-enforce the team's awareness. And it had SOPs covering confidentiality and data protection that all team members had signed. The staff handbook included a confidentiality code of conduct signed by the team. The team had completed training on the General Data Protection Regulations (GDPR) especially when handling telephone calls. The pharmacy website included a privacy notice. The pharmacy stored confidential waste in a dedicated bin for shredding off site.

The pharmacy had safeguarding procedures and guidance for the team members to help them understand their role in protecting vulnerable people. And team members had access to contact numbers for safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults in 2020. The team responded well when safeguarding concerns arose.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a team with the appropriate qualifications and skills to support its services. And it is good at supporting its team members to complete further relevant qualifications and training. The pharmacy actively encourages team members to share ideas on how to improve the delivery of its services. And they are comfortable making suggestions. The team members keenly use such opportunities to improve the efficiency and safety in the way they work.

### Inspector's evidence

A full-time employed pharmacist covered most of the opening hours. The Superintendent Pharmacist (SI) regularly worked in the pharmacy and on occasions was signed in as the Responsible Pharmacist (RP). The pharmacy occasionally used locum pharmacists. The pharmacy team consisted of an accuracy checking technician (ACT), two trainee pharmacy technicians and three dispensers. The team members were allocated specific roles. One of the dispensers was the office purchasing manager. And the trainee technicians were responsible for processing and labelling prescriptions following the pharmacist's clinical check. Team members worked well together in an organised way and could manage the workload.

Team members completed regular ongoing learning related to the safe running of the pharmacy and the medicines dispensed in the pharmacy. Many prescriptions originated from a clinic specialising in the treatment of the menopause. The pharmacist and team members showed a good knowledge of the medicines and doses prescribed by the prescribers at the clinic. And they were confident contacting the prescribers with any queries on the prescriptions. The team members were aware of which medicines were used off-licence and the doses used.

When a new clinic and prescribers registered with the pharmacy the team spent time gathering information about the medical treatments provided by the clinic and the equipment needed such as needles and sharps bins. This meant they could be confident dispensing prescriptions once they started to arrive at the pharmacy. A clinic had recently registered that provided medicines the team had not dispensed before. The SI circulated information relating to the medicines that would be prescribed by the clinic for the team to read and understand. This had triggered one of the dispensers to read more about the medicines prescribed to improve their knowledge before receiving any prescriptions. However, the pharmacy didn't have access to the prescribing policies of the registered prescribers to provide the pharmacists and pharmacy team with additional clinical information when checking and dispensing prescriptions.

The team held regular meetings including a clinical review meeting. Team members were encouraged to suggest changes to processes or discuss new ideas of working at these meetings. The SI kept the team members up to date with the pharmacy operations by circulating information and discussing matters at the meetings. Team members felt comfortable raising concerns or sharing ideas with the SI. And felt their concerns would be addressed. At a recent meeting the team expressed concerns about the increased number of prescriptions for amitriptyline. The team recognised this was a medicine that could be liable to misuse. And discussed adding it to the list of medicines in the SOPs that were to be monitored by the team. The pharmacy provided performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs. The pharmacy

didn't have a whistleblowing policy for the team to raise any serious concerns anonymously.



## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are spacious, clean and secure. They offer a professional environment for the services provided. The pharmacy's website provides relevant information about its private prescribing platform. And people using the pharmacy can find up-to-date contact information there.

### Inspector's evidence

The pharmacy was within a modern office block and in a good state of repair. The dispensing area was large, bright and airy with plenty of bench space for the team to work from. The team members kept the pharmacy clean and tidy. And they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had separate sinks for the preparation of medicines and hand washing, with hot and cold water available. The pharmacy had air conditioning and heating to provide a comfortable temperature for working. The pharmacy provided the team with facilities to have lunch breaks.

The pharmacy had systems installed to secure the premises. It had frosted windows to prevent anyone outside from seeing into the pharmacy. And it had an intercom to manage visitors and access to the premises. People had to ring the buzzer to gain access to the pharmacy. There was a communal reception area used with one other company in the same building.

People could not arrange a consultation with a prescriber via the pharmacy. The pharmacy website was aimed at providing information to private prescribers about the pharmacy's prescribing platform. It clearly described the service for prescribers. The pharmacy's interaction with the person receiving the medicine only came once the prescriber was registered with the pharmacy. And sent the person's electronic prescription to the pharmacy through the prescribing platform. People, including those receiving medicines from the pharmacy could access the website for details about the pharmacy. It provided details of the pharmacy GPhC registration number and the name and GPhC registration number of the Superintendent Pharmacist. The SI confirmed that the website was secure and complied with data protection regulations and information security management guidelines. The website provided a clear set of terms of use and details of the privacy and security policy.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy has some suitable systems to help manage its services safely. But it doesn't have all the necessary safeguards in place to monitor supplies it makes, including following online prescriber consultations. The team members make sure people receive their medicines when they need them. And they have some robust procedures in place to ensure people receive relevant information about their medicines. However, the pharmacy's clinical guidelines don't fully reflect national guidance to ensure the safe and appropriate supply of medicines to people. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy was closed to the public which meant people could not access the pharmacy in person. People could contact the pharmacy team for advice or support via telephone and email, the details of which were published on the pharmacy website. The pharmacy had several telephones which meant one of the team could quickly answer the phone. The team regularly checked the emails throughout the day to ensure urgent ones were not missed. The pharmacy system used coloured flags to indicate the different stages the dispensing of the prescription was at. This helped the team answer people's queries about the processing of their prescriptions.

On completion of the registration process the prescriber received secure and unique access to the platform. This allowed the generation of prescriptions with a valid electronic signature. The pharmacy registered prescribers' administrators allowing them access to the platform, but they did not have prescribing rights. The pharmacy platform prevented anyone other than the registered prescriber from sending the prescription to the pharmacy. The registered prescriber could amend or cancel the prescription at any point and they could monitor the progress of the prescription at the pharmacy. The prescribers could also see their previous prescription orders.

The pharmacy team met with some of the prescriber(s) once they registered as part of the quality assurance process to find out about the clinic, the medical conditions and treatments the prescriber(s) provided for. This helped identify any training needs for the team. The team also took the opportunity to explain how the pharmacy's prescribing platform operated and the pharmacy's procedures for dispensing prescriptions. This approach provided a basis for the pharmacy team to establish a working relationship with the prescribers for future communications such as prescription queries.

Following a consultation, the registered prescriber obtained consent from the person to send their electronic prescription to this pharmacy or to another pharmacy the person chose. The prescriber provided the pharmacy with the person's contact details and the team emailed or sent a text message to the person advising of the receipt of their prescription and requesting payment. The pharmacy took a secure payment before the prescription was dispensed. The pharmacy regularly reminded people by email and telephone calls if no payment was made, to ensure they had the opportunity to receive their medicines in a timely manner. And held the prescription, unless it was for controlled drugs (CDs), on the system for six months. The team informed the prescriber of any prescriptions not dispensed due to non-payment or when the person cancelled the prescription. The prescriber had the option to create repeat prescriptions. This meant the person could contact the pharmacy when they needed more

medication. And the pharmacy would issue the next supply from the repeat prescription.

Once the payment was made the pharmacist completed a clinical check of the prescription before it was released for dispensing. The pharmacy had a set of clinical guidelines embedded in the SOPs for the pharmacist to follow. The guidelines included when a clinical decision should be made on the maximum number of supplies of certain medication. The medicines listed were mostly items that could be misused. However, some of the clinical guidelines did not reflect national guidelines produced by organisations such as the National Institute for Health and Care Excellence (NICE). This included salbutamol inhalers that the pharmacy's clinical guidelines indicated a maximum of three supplies a month. Whereas national guidelines refer to no more than one inhaler to be supplied a month. The pharmacy's clinical guidelines stated there should be a maximum of 30 days' supply of co-codamol 30/500 per person. And no more than six issues of co-codamol per person. After that any further prescriptions would be declined and discussed with the prescriber. However, for a private prescriber who may not be the person's usual prescriber these criteria may not prevent a vulnerable person from being at risk of overusing.

Following the inspection, the SI provided data showing over a period of time that most people received only one supply of the medicines listed in the clinical guidance. A few people had received two supplies. The pharmacist's clinical check of the prescription included the frequency of supplies. The pharmacist contacted prescribers with queries on individual prescriptions. And the team sometimes discussed matters such as an increase in the prescribing of individual medication such as amitriptyline. The pharmacy system highlighted people with similar names and people with different names at the same address and postcode. This enabled the team to ensure the supplies were made to the correct person. And to identify individual people with duplicate accounts. However, the team didn't regularly audit all the medicines supplied to identify trends and any requests, particularly from people using the online prescribing service, that were from the same address or had duplicate accounts and where prescriptions were issued by the same prescriber. Or whether duplicate requests were appropriate. The pharmacy team members didn't regularly complete audits of the medicines they dispensed to identify any areas of concern and whether the supplies were within their clinical guidelines. The online prescribers including those from outside the UK wrote prescriptions for a range of medicines including co-codamol, amitriptyline, antibiotics and Saxenda, for weight loss. Some of these required ongoing monitoring and knowledge of UK antimicrobial stewardship. The data provided by the pharmacy after the inspection showed a few duplicate requests for antibiotics, co-codamol and Saxenda. Whilst these supplies may have been checked by the prescriber and be appropriate, the pharmacy did not have checks in place or information from the prescriber to ensure this was so. Saxenda required ongoing monitoring and the pharmacy did not know if all the prescribers completed these effectively or shared the information with the GP.

The pharmacist used the pharmacy's patient medication record (PMR) held in the pharmacy to check the person's history of the medicines supplied to help ensure the prescription was appropriate. The pharmacist put on hold prescriptions written with 'as directed' doses and contacted the prescriber asking for specific directions to be added. The pharmacist reported this process helped prescribers understand the importance of writing clear doses. And as a result, the pharmacist noticed fewer prescriptions with 'as directed' doses were sent to the pharmacy. The pharmacy dispensed CD prescriptions for a few hospital clinics on NHS FP10PCD forms. The team used the monthly CD balance check to assess the number of prescriptions dispensed per month for a prescriber and for a particular person as part of the monitoring of prescribing. However, the pharmacy didn't keep a record of this assessment.

The pharmacist and team members were aware of the professional requirements for some higher risk medicines. For example, when they dispensed isotretinoin for one clinic, they checked the electronic

prescription for details and the date of a negative pregnancy test. This information was referred to throughout the dispensing and checking processes. The pharmacist and team members had the required knowledge to clinically check and dispense the weight loss product, Saxenda. They knew the dosage regime and checked the dispensing history to ensure the dose and volume for the person to administer was appropriate for the stage in their treatment. However, the pharmacy's current prescribing platform meant the pharmacist and pharmacy team didn't have access to the person's records to check clinical information such as blood test results or a person's BMI. They relied on the prescriber to prescribe within the licenced recommendations. The pharmacy had gained some assurances, for example the pharmacist and SI had met with prescribers at the weight loss clinic to understand the clinic's processes and prescribing protocols. However, the team didn't know on an individual basis if prescribers were adhering to their protocols or if the prescriber had liaised with the person's GP about treatment. The team sent letters to people's GPs following the supply of antibiotics and asthma treatments from one of the online prescribing services. The team showed recently printed letters which clearly informed the GP of the medication and quantity supplied and when the supply was made.

Following the clinical check, a dispatch note and barcode delivery labels were printed and put in dispensing baskets. This meant the prescription information and delivery address were checked at each stage of the dispensing and checking process. The team provided people with clear advice on how to use their medicines. All the information written by the prescriber that was relevant to the person was added to the dispensing label. For example, a prescription for antibiotics to treat dental pain in an emergency included advice to the person to make an appointment with their dentist as soon as possible. Occasionally the pharmacy team received prescriptions with dosages written in another language. The pharmacist when performing the clinical check contacted the prescriber to confirm that the alternate language was required. And to check with the prescriber that the translation obtained using a recognised translation platform was correct. Once the correct translation was agreed the pharmacist ensured the information provided to the person on the dispensing label was in English and the other language. The dose in the other language was added to the dispatch note that was sent to the person and the person was directed to this. This helped to ensure the person understood how to take their medication. The dispatch note sent with the supply contained a unique order number. The last digit indicated the number of times the person had received the medicine from the pharmacy. A zero number triggered the team to place information leaflets in with the medicines to help the person understand how to take their medicines. The pharmacy team sometimes received queries from people either by telephone or email. And the pharmacist provided additional counselling to the person about their medication by speaking to them or via an email. The team signposted some queries to the prescribers and helped people resolve their questions with the prescriber if required.

The team used different coloured baskets for separate clinics and also for the courier used. This enabled the team to prioritise prescriptions for couriers that collected earlier in the day. The pharmacy completed most prescriptions with few prescribed items being owed to the person. The pharmacy monitored the number of owings to enable the team to act such as reviewing stock levels. Pharmacy team members were allocated a number to use when initialling the dispensed by and checked by box on the dispensing labels. This enabled the pharmacy to identify who in the team had dispensed and checked the prescription, especially when an error occurred. It was an efficient way of working and it helped improve impartiality when analysing errors.

The pharmacy used discreet, sturdy cardboard boxes of varying sizes to deliver people's medicines. Most supplies were made as a next day tracked delivery service via Royal Mail or another recognised courier. When this was not possible the team contacted the person to advise them of the delay. The team stored the medicines for different delivery options separately and in an organised manner. When the person was not at home to receive the medication, it was returned to the pharmacy. The team

checked the packaging for damage before signing for receipt of the returned medication. The team contacted the prescriber to advise the medication had been returned so they could contact the person and establish if the medication was to be resent.

The pharmacy obtained medication from several reputable sources. The pharmacy kept the shelves holding medicine stock neat and tidy. The shelves were labelled with the medicine's name to help the team accurately select the product. The pharmacy team regularly checked the temperature of the fridge and kept an electronic record. The records looked at were within the required range. The team members regularly checked the expiry dates of medicines and recorded when these checks had been completed. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. Pharmacy team members received medicine recall alerts by email and actioned them appropriately. They recorded their actions on a spread sheet for reference.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

### Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication.

The pharmacy computers were password protected and data was encrypted to ensure people's confidential information was protected. The pharmacy computer system was regularly backed-up as a Cloud based and there was 24/7 access to IT support.

### 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.