General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Simple Online Pharmacy, 77 Dunn Street, Glasgow, G40 3PA

Pharmacy reference: 9011287

Type of pharmacy: Internet / distance selling

Date of inspection: 20/09/2021

Pharmacy context

The pharmacy is on a main road in the east end of Glasgow. It is a distance selling pharmacy and closed to the public. People access its services through its website or by telephone, rather than directly from the premises. It is a hub pharmacy and dispenses for the other pharmacies in the company. This includes medicines in multi-compartment compliance packs and pouches to help people take their medicines correctly. The pharmacy operates an online prescribing service and sells over-the-counter medicines from its website https://nhs.simpleonlinepharmacy.co.uk. It dispenses private prescriptions. Conditions on the pharmacy's registration are in place at this pharmacy premises. These conditions were imposed after failings were identified at a previous inspection and they remain in force at the time of this inspection. The inspection was completed 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
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website doesn't adequately meet requirements to ensure people receive safe care. It allows people to select the medicine they want before they have a consultation with the pharmacy's prescriber. This means people may not receive the most suitable treatment for their needs.
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 mostly identifies and manages the risks with the services it provides, including when making changes to its services. And it mostly implements the necessary changes to manage risks, including for its online prescribing service. The pharmacy regularly assesses the safety and quality of its services and identifies where it can improve. And it adequately identifies and supports vulnerable people accessing its online prescribing service. It keeps people's private information secure.

Inspector's evidence

The pharmacy had undertaken a risk assessment and introduced extra control measures to manage the risks and help prevent the spread of coronavirus. Hand sanitizer was available at the reception desk for visitors to use. And a screen acted as a barrier between team members and people who entered the premises. Notices on the door at the entrance reminded people to wear a face covering and to observe social distancing measures. Team members were wearing face masks throughout the inspection and an automated prompt made them apply hand sanitizer on a frequent basis. In March 2021 extra social distancing measures were introduced following a Covid-19 outbreak amongst team members. The pharmacy had extra rooms which they used for comfort breaks. And a new seated outdoor area had been created over the summer months to provide increased capacity. Following the outbreak new rotas were implemented so that the same pharmacy team used the same rest room with their colleagues. This helped to manage the risk of new infections.

The new superintendent pharmacist was a qualified ‘pharmacist independent prescriber’ (PIP). They had been in post for around 10 months. On taking up their role they carried out a service review focussing at first on the risks associated with the online sales of ‘pharmacy only’ (P) medicines. This was due to regulatory conditions imposed on the pharmacy’s registration following an inspection on 1 October 2020. The conditions prevented codeine linctus and promethazine sales and supply due to the pharmacy having inadequate safety measures to safely control these. They completed a risk assessment for the online sales of P medicines on 27 November 2020. A ‘corrective action preventive action’ (CAPA) document showed the findings from the review. And on 7 December 2020 the superintendent had signed the document to confirm that the improvement actions had been completed. This included removing all codeine products, sleeping tablets and diphenhydramine tablets for sale from the pharmacy's website. It also included the introduction of postcode checks for products liable for misuse, such as codeine-containing products, Sudafed, and sedating antihistamines. In November 2020 the content writing clinical pharmacist ‘The Risks of Addiction to Over-the-Counter Codeine Products’. The blog described codeine addiction and signposted people to various agencies for support. A new documented procedure for 'Selling P and GSL Medicines Online' described the new arrangements and the superintendent authorised it for use from December 2020. An updated ‘Online sale of products containing codeine and dihydrocodeine’ procedure dated June 2021 showed that as of March 2021 sales of codeine and dihydrocodeine containing products had been recommenced. A restriction of one pack every three months to one household was in place. The responsible pharmacist carried out three-monthly audits to confirm that postcode checks were effective at restricting sales. For example, sampling of three orders between 1 March and 31 May 2021 and 1 June and 31 August 2021 showed the checks had been effective at restricting sales. The pharmacy used third party identity checks to manage inappropriate sales of high-risk medicines such as codeine-containing products. Other products

such as laxatives could be accessed by patients without a full identity check even though they were liable for misuse. The pharmacy evidenced the effectiveness of their control measures through rejections. For example, the prescriber rejected a request for Viagra Connect and recorded the person needed to see their own GP for a cardiovascular risk assessment.

The pharmacy had defined its dispensing processes in a range of documented procedures. Team members followed the pharmacy's policies and procedures according to their roles and responsibilities. The superintendent pharmacist ensured they were reviewed on a regular basis and sampling showed they were up to date. The procedures defined dispensing for a range of different prescriptions,, multi-compartment compliance packs including a pouch system and supplies of P medicines.

The pharmacy had introduced a new patient medication record (PMR) system with an integrated barcode verification function the week before the inspection. It had reviewed the manufacturer's safety data. And was now conducting its own tests to compare the barcode verification checks against the final accuracy check carried out by a pharmacist or ACT. When tests are completed final barcode verification will replace the checks carried out by a pharmacist and ACT in some circumstances.

The pharmacy regularly reviewed the quality of the online prescribing service. It kept minutes of its 'quality meetings' to show the improvements and the rationale for the changes. The superintendent pharmacist, the regular responsible pharmacist, the clinical pharmacist/content writer, and the GP prescribers attended the meeting. The clinical pharmacist/content writer was responsible for writing and updating the assessment forms and producing content for the website such as patient information. The minutes of a meeting on 27 April 2021 showed actions that had been agreed to improve the online prescribing service. This included adding extra safeguards to protect vulnerable people. For example, adding blocks so that people could not order orlistat and Saxenda medication together. The blocks also prevented laxatives being purchased at the same time as weight loss medication. An incident involving the pharmacy's digital marketing team had been discussed. The team had put vape products on the website without seeking authorisation from the superintendent. The products were removed, and a policy change had been agreed which meant that no products could be added without the superintendent's authorisation. The patient care team had raised concerns about an increase in queries from transgender patients regarding medicine requests. The clinical pharmacist/content writer carried out a review and found that the online assessment forms were not inclusive of the LGBTQ community. Following a clinical meeting the pharmacist agreed to contact 'Mermaids' a charity that supports transgender, non-binary and gender-diverse children, young people, and their families. They also consulted the NHS content style guide on inclusive language. Extra questions were added to the relevant assessment questionnaires, for example, the finasteride questionnaire asked whether patients were transitioning from male to female. And for trimethoprim and nitrofurantoin whether people were transitioning from female to male. In December 2020, the pharmacy had reviewed and updated its assessment questionnaires. This included for asthma and COPD, erectile dysfunction, hair loss and weight management. It also reviewed and updated its policies and procedures. The antibiotic policy had been reviewed in December 2020 and included guidance about best practice in antibiotic stewardship. A list of high-risk medicines with the associated restrictions had been updated in September 2021. For example, only two Ventolin inhalers could be supplied within a 90-day period. Sampling showed the pharmacy's blocks effectively restricting supplies.

The ongoing monitoring of services included records of near miss errors, incidents and complaints and the learning taken from these. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. They carried out regular reviews of near miss errors to identify patterns and trends. They had implemented changes and improvements to manage the risk of dispensing errors. For example, shelf edge caution labels to highlight the different strengths and

different pack sizes of sildenafil. A documented review of near-miss errors for June 2021 described form and strength as the most common cause of errors. It highlighted the following selection errors; aspirin dispersible instead of the regular formulation, beclomethasone nasal spray instead of inhaler, Ventolin Evohaler instead of Salamol Easi-breathe, Novorapid Flexpen instead of Flextouch and indapamide 2.5mg instead of 1.5mg M/R. The information was cascaded to the pharmacy teams so they were aware of the risks. The review also highlighted the risk of dispensing errors and need for extra care at the clinical export of pouch processing. The patient care team spoke to people on the phone and responded to emails. This included handling complaints about dispensing incidents. They knew to ask for photographs of labels and the affected packs to relay to the responsible pharmacist for investigation. They maintained records of dispensing incidents and produced monthly reports with 'month on month' comparisons showing trends and types of errors for each of the services. For example, it showed the number of dispensing errors had fallen by 20 between June and July 2021. They kept a notice board in the customer service team area to highlight significant risks. The information was dated, and it was seen to be up to date. A copy of a recent PowerPoint presentation showed the learnings and actions identified by the patient care team for July 2021. They presented the information to senior staff and cascaded the learnings to the rest of the team members. Actions included the introduction of 'one to ones' to highlight the seriousness of incidents. And to ensure that multi-compartment compliance packs were assembled for delivery in advance of them being needed. The superintendent pharmacist had issued a 'GPhC Standards Checklist' to the team leaders who reviewed their section's compliance with professional standards, and to show where improvement action was needed. The superintendent had oversight of the process and discussed the findings with the team leaders. For example, using the pharmacy safe or a locked cupboard for the secure storage of highly sensitive information.

The pharmacy provided training so that the patient care team effectively managed complaints. It used Trustpilot.com so that people could provide reviews about the services they received. Team members monitored the ratings which were mostly 'excellent'. They investigated 'bad' reviews so they could learn from them and try to correct them. Team members had recently contacted two people who had left raised concerns through their reviews. The pharmacy used Royal Mail and deliveries were tracked. For one of the reviews, they found that Royal Mail had placed a Saxenda delivery, including the cold packs into a plastic bag and advised the person to complain. This had been due to condensation signs on the packaging. The person had been unable to contact the pharmacy over the weekend and had then left the bad review. The team member had contacted the complainant and advised that Saxenda could be used for up to 30 days at room temperature. They arranged a new supply and refunded the postage costs which they claimed back from Royal Mail. Complaints were mostly due to late orders which had been caused by the Covid-19 pandemic. The pharmacy recorded all calls and team members were able to listen back to them.

The pharmacy maintained the records it needed to by law. The pharmacist in charge displayed a responsible pharmacist (RP) notice. They maintained the responsible pharmacist record and documented the time they ceased their RP responsibilities. The pharmacy dispensed private prescriptions that people sent via the postal system. And team members conducted GMC checks on all prescribers. The private prescription register was in satisfactory order and up to date. The pharmacy had valid public liability and professional indemnity insurance in place until 16 October 2022. And prescribers had indemnity insurance in place until 27 March 2022. The pharmacy maintained its electronic controlled drug registers and team members kept them up to date. They checked and verified the controlled drug stock at the time it was dispensed. Sampling showed the balance of registered stock matched the actual stock. Team members segregated controlled drugs that had expired whilst they awaited destruction by the accountable officer at the health board. The pharmacy provided training so that team members understood how to protect people's privacy. And a named Data Protection Officer had been nominated to handle security breaches. A procedure for the use of 'Summary Care Records' and the necessary control measures described how to safeguard people's

personal information. The team placed confidential waste in designated containers that were collected for off-site destruction. The pharmacy trained team members to safeguard vulnerable people. This included training to recognise the signs and symptoms of poor mental health. The pharmacy had a safeguarding policy and contact details were available for team members to refer to. A notice provided contact details for key agencies across Scotland and England. A whistleblowing policy was also in place. Team members knew their vulnerable patient groups and knew to refer to the pharmacist for advice on the best way to manage concerns. They were able to provide several examples of safeguarding incidents and they recorded details of each incident on people's 'patient medication record' (PMR).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the right qualifications and skills to provide the pharmacy's services safely. And they have opportunities to complete ongoing training. The pharmacy supports trainees with protected learning time during working hours. Team members manage the workload well and support each other as they work. And pharmacists and prescribers engage on a regular basis to agree clinical decisions.

Inspector's evidence

The superintendent pharmacist had been in post for around 10 months. And the responsible pharmacist had worked at the pharmacy for over two years. They were both present during the inspection and were being supported by a locum pharmacist who had previously worked at the pharmacy. Both directors, also pharmacists were on-site and provided support. The pharmacy employed GP prescribers to provide its online prescribing service. They received a salary and were not incentivised by the number of prescriptions they produced. They worked together as a team and one prescriber at a time provided cover each day. The directors didn't attend all the meetings that the prescribers attended. This removed the risk of financial pressure and helped to maintain quality in prescribing and patient safety. The pharmacists and the prescribers worked well together and they used an instant messaging function. This meant they could communicate with each other within about 10 minutes. The pharmacy used the same locum pharmacists and team members in each of the service areas supported them in their roles. The regular responsible pharmacist had also introduced a locum information folder for them to refer to. Only experienced locums were used on a Saturday due to reduced staffing levels.

The capacity of the workforce had increased, and more dispensers had been recruited to facilitate the safe introduction of a new PMR dispensing system. Dispensers had watched training videos so they could learn about the new system. This included only scanning one pack at a time including for multiple packs of the same product. Ten full-time dispensers were in post, two of whom were trainees. The pharmacy allocated the trainees four hours training time per week. The pharmacists and the ACTs continued to carry out the final accuracy checks for all prescriptions. This arrangement would change following full implementation when the superintendent had sufficient evidence to show the system and ways of working were safe. Only then would relevant final checks be verified using the barcode technology. New standard operating procedures would be introduced at the same time.

A new ACT had been appointed the previous month. They were undergoing a probationary period before being authorised to carry out the final accuracy check of prescriptions. The pharmacy used a formal induction process and documentation for new team members. They signed the document when they were deemed competent. The new ACT had experience of working in both hospital pharmacy and community pharmacy settings. And the superintendent had appointed them to carry out service reviews and to identify areas for improvement. They had read the company's standard operating procedures and had suggested putting the review date on the front page for improved visibility. They were currently reviewing the use of the dispensing robot to identify any areas for improvement. The pharmacy had increased the number of advisors in the patient care team from three to six to help manage the increased call volumes for each of the services the pharmacy provided. As well as

answering calls, tasks included contacting people on behalf of each of the pharmacy teams for more information. The superintendent encouraged them to take a short break after difficult calls to protect their mental health. For example, it was sometimes stressful explaining those requests that they had rejected due to the pharmacy's policies and procedures.

The patient care team members were clear about their roles and responsibilities and didn't complete any dispensing tasks. Dispensing teams worked in separate areas depending on the tasks they carried out. The teams were currently fixed, and the rotas were remaining the same due to the pace of change. This provided stability and expertise to manage the risks associated with significant service transformation. Pharmacy teams were seen to be working well together and managing the workload. Team leaders were responsible for their team's performance and to ensure team members were working safely and effectively. This included the sharing of information such as safety information and learnings from near-miss reviews and incidents. The pharmacy had regular meetings and information was disseminated across the organisation. This included a weekly 'quality meeting' between the superintendent pharmacist, the pharmacist who was responsible for the website content and the GPs. They discussed new products, changes to assessment forms and any issues that needed discussion. A fortnightly management meeting and various other meetings took place including superintendent calls to the other pharmacies in the company. A six-monthly clinical meeting was held with the director, the superintendent, and the GP prescribers. A lead GP prescriber carried out performance appraisals with the other GP prescribers. This included a review of their 'personal development plans' (PDP) and 'continuing professional development' (CPD). The prescribers audited each other's consultations. This provided the opportunity for shared learning and to improve clinical decision making and patient outcomes. A recent audit found that the doctors agreed with their colleague's decision in all but one example. This was due to the BMI threshold. This led to a discussion between the prescribers about measuring BMI and whether it should be rounded up. They agreed that BMI numbers should not be rounded up or down to ensure consistency when assessing a patient's BMI.

The superintendent held a daily huddle with the team leaders who disseminated information to their teams. There was good communication between teams using instant messaging. The pharmacy had a system in place for performance appraisal for each team member. The next appraisal was scheduled for November 2021. This helped to keep the team members' knowledge and skills up to date. For example, a company representative had provided onsite training about Saxenda and its use in weight loss.

Some of the patient care team members had worked in high street pharmacies and others were new to the pharmacy sector. During induction, they had completed training such as conflict resolution and safeguarding vulnerable adults. One of the team members produced a guidance document that showed learning about what good customer service looked like. It included communication skills and how to apply the pharmacy's values when speaking to people. A pharmacy technician and a dispenser supported a new clinical administration team and had provided learning resources to help them carry out their roles. This included common Latin prescription abbreviations and products liable to misuse.

The pharmacy used real life examples of customer queries and complaints to provide learning opportunities for the staff. The teams using instant messaging to communicate with each other. And team members audited the channel on a regular basis to identify training needs and the pharmacy teams were updated.

The pharmacy encouraged team members to provide feedback and raise concerns. As a result, an outside seating area was created to help team members keep a safe distance from each other. The responsible pharmacist had requested changes to the Saturday working arrangements to reduce the volume of orders they had to process on a Monday, and this had been agreed and implemented. A 'staff wellbeing' policy had been introduced on 1 September 2021. This included increases to the

holiday allowance which was backdated to everyone's start date. It also described a 'personal learning budget' that was due to be introduced in 2022.

Principle 3 - Premises **Standards not all met**

Summary findings

People generally access pharmacy services through its website. But the website doesn't adequately meet GPhC requirements. It allows people to select the medicine they want before starting a prescriber's consultation questionnaire for their condition. This means people may not receive the most suitable treatment for their needs. The pharmacy keeps its premises suitably clean and secure. It has adequate space for the activities it carries out.

Inspector's evidence

The pharmacy was in a large, modern, purpose-built premises. It was over two floors and team members carried out their roles and responsibilities for each of the services in well-segregated areas. The large ground floor area had been recently transformed to accommodate large dispensing benches for the new PMR and dispensing system. Team members were in the process of improving the bench space. This included raising the PMR monitors above the bench and concealing all the cables. The mezzanine floor had been organised into separate areas for dispensing ‘pharmacy only’ (P) medicines, ‘prescription only medicines’ (POM) for the online prescribing service, medicines in multi-compartment compliance packs and a pouch system. The pharmacy was in a good state of repair. It had a handrail on the stairs up to the mezzanine floor to help prevent falls. Lighting and the ambient temperature were adequate throughout. Staff rooms and toilet facilities were located on the ground floor and a new seated outdoor area was available for team members.

The pharmacy employed a person to carry out cleaning duties in the downstairs areas. Team members cleaned the dispensary and the equipment they used for dispensing. They kept records of the cleaning activities they undertook. Large office spaces were available and used for the various meetings that took place. A call centre was used by the patient services team. It had sound-proofed booths and telephone conversations were carried out in private.

The pharmacy’s website displayed the voluntary GPhC logo. The name and physical address of the pharmacy was displayed on the website and the registration status of the pharmacy could be found by following the link from the GPhC logo. The website displayed the name and registration number of the superintendent pharmacist on the ‘about us’ page. The website also displayed the names and registration numbers of the GP prescribers for the online prescribing service. People accessed the consultation directly from the page detailing the treatment rather than the conditions page. This meant that people selected the medicine before completing the prescriber's consultation questionnaire. It was also possible to search for a specific medicine by using the website’s search box. Once the user selected a medicine, they were presented with the questionnaire. This suggested the person and not the prescriber selected the treatment for the person’s condition. Under each condition the different names of products were shown and their starting price, and it was possible to start the questionnaire from the medicine itself, rather than from the condition. This wasn’t in line with GPhC guidance and means people may not always receive the most suitable medicines for their needs.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has sufficient safeguards in place to ensure it manages all its services safely. And it uses technology to help improve the safety and efficiency of its services. Prescribers keep suitable records of clinical decisions as part of the pharmacy's prescribing service. And they check that people using the online prescribing service have the ongoing health checks they need. And they share relevant information with other healthcare providers. The pharmacy obtains its medicines from appropriate sources. And the team carries out regular checks on its medicines to make sure they are fit for purpose.

Inspector's evidence

The pharmacy premises were closed to the public and people accessed services through its website and by contacting the pharmacy by telephone and email. The pharmacy's website detailed how to access services. This included explaining how to access the online prescribing service and the sale of medicines. The pharmacy dispensed prescriptions for Davis Chemist. This included medicines in multi-compartment compliance packs and pouches. Davis Chemist was England, providing NHS services and part of the same legal entity as Simple Online pharmacy. Sampling showed Davis Chemist on some dispensing labels and Simple Online Pharmacy on others when they should show the medicines had been assembled at Simple Online Pharmacy and supplied by Davis Chemist so people know who to contact. The responsible pharmacist at Davis Chemist was responsible for carrying out the clinical check of the prescriptions and access to the prescriptions was controlled. They conducted the clinical check before they released prescriptions for dispensing. The pharmacy dispensed for another of its branches in Aberdeen, but this only amounted to a small number of pouches.

The pharmacy was in the process of introducing a new PMR system to help improve the safety and effectiveness of its dispensing processes. The system also better integrated with the pharmacy's bespoke systems. This included the platform used to communicate with the prescribers at the online prescribing service. Prescriptions for dispensing remained in the system and dispensers referred to a printed 'picking list' to select medicines. Dispensers then scanned the barcodes on the manufacturer's pack and only if the correct pack had been selected was a dispensing label produced. This helped reduce selection errors. Two separate dispensing benches were in use. One of the benches was used to dispense medicines in their original packs and the second bench was used to dispense part-packs. Team members had been trained to use the system and they emphasised that they must scan one pack at a time for accuracy even for multiple packs of the same medication. This mitigated the risk of labelling an incorrectly selected pack. A pharmacist and an ACT continued to carry out the final accuracy checks. But once the system was fully embedded, and the accuracy of the system checked, a dispenser would use its bar-code verification system to complete the final accuracy check for certain agreed prescriptions. The superintendent had oversight of the system. This included monitoring the prescription queue. They were able to deploy extra team members to help manage long dispensing queues.

The new PMR system scanned some expiry date information from barcodes on the packs. This helped team members manage the risk of supplying out-of-date medicines. Team members also evidenced a matrix to show they manually checked expiry dates. A medical fridge was used to store medicines

requiring cold storage. Team members monitored and recorded the fridge temperatures every morning. The records showed that the temperatures had remained between two and eight degrees Celsius. Team members processed drug alerts straight away. They printed them and checked for affected stock so that it was removed and quarantined. A recent drug alert for Ikervis eye drops showed when the checks had been carried out and what the outcome had been. The pharmacy had medical waste bins to support the team in managing pharmaceutical waste. A procedure for dispensing valproate was available for team members to refer to. They were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacy had audited the sodium valproate dispensing process to confirm patient warning cards were being issued. This followed an incident when a patient warning card had not been included with supplies.

The pharmacy acted as a hub and used a robot to dispense compliance pouches on behalf of another branch in the company. Team members managed the workload over a four-week cycle and assembled the pouches a week in advance of their due date. They ordered new prescriptions on behalf of the other branch for some people and other people ordered their own. The patient care team had to contact people when their prescriptions didn't arrive. And they were in discussions with them so the pharmacy could order their prescriptions so they didn't run out. The dispensing robot had 480 spaces for canisters for individual medicines. The canisters contained desiccants and only 207 spaces were in use for fast moving stock. This helped to reduce the risk of stability problems. The robot manufacturer produced stability information and team members excluded certain products as recommended. Safety features were built into the robot so that dispensing was accurate. The canister bases were designed for certain products, such as different tablet shapes and capsules. They had unique pin arrangements on their base, and they could only fit one unique position inside the robot. Team members de-blistered products into the canisters and scanned the barcode on the packs. They also scanned a barcode on each of the canisters at the same time so it was clear which medicines were contained in which canisters. Team members had their own log-on credentials and there was restricted access to the robot. Audit trails of the tasks that team members carried out were kept. For example, the robot recorded who filled each canister. Not all medicines were dispensed from the canisters. And team members manually added these medicines to the robot's removable tray for dispensing. A pharmacist carried out an accuracy check after a dispenser manually filled these trays. Team members then instructed the robot to dispense them into the pouches. After assembly a dispenser removed the pouches from the robot and placed them onto a machine that photographed each pouch. The images were sent to another computer and the pharmacist checked them for accuracy. The computer kept audit trails of the checks the pharmacist carried out. The robot identified inaccuracies and anomalies. Often this was due to a change of brand or one tablet obscuring another. The pharmacy was working with manufacturers to minimise the number of brands being used. A regular locum was on duty at the time of the inspection and was competent in the robot operations. A signature audit trail was used to show who had dispensed and who had checked the pouches. Team members supplied ‘patient information leaflets’ (PILs) with the first pack of the four-week cycle. They also provided a medication administration record (MAR) sheet which they annotated with descriptions of the medicines. Information on the pouches included the day and time of administration and listed the tablets it contained. Team members added ‘controlled drugs’ (CDs) to the pouches on the day they were supplied due to limited storage capacity in the CD cabinet.

The pharmacy had an upstairs mezzanine area for dispensing the ‘pharmacy only’ (P) medicine sales. And a separate area for dispensing the ‘prescription only medicines’ (POMs) for the online prescribing service. Red dispensing baskets indicated a next day delivery and green baskets for items required within 48 hours. Once packaged, supplies were placed in chutes which went directly into bags in cages for Royal Mail collection. The pharmacy had a process in place for packaging Saxenda medication. Team members ‘sandwiched’ the Saxenda between cool packs before placing in the packaging. The pharmacy

had audited different cool packs to assure the temperature on receipt the following day. Royal Mail tracked medication deliveries.

To access the online prescribing service people had to create an account and complete the online assessment for the GP prescribers to review. But the person and not the prescriber chose the POM medicine to be prescribed. The prescribers would either authorise supplies and issue a prescription or reject requests. The system used an algorithm to support the prescribing decisions. Assessment forms were RAG rated into red, amber, and green categories to highlight the risks. When the prescribers rejected orders, they documented the clinical reason for their decisions on the person's record. Sampling showed many examples of rejections, such as BMIs being too low for orlistat medication, and people greater than 75 years of age requesting sildenafil. Records also showed communication when people had been stopped from future ordering due to duplicate requests or trying to circumvent the pharmacy's ordering systems. The pharmacists had access to assessment questionnaires and medication histories. The dispensers could only see prescriptions. People requesting medication for long-term conditions had to provide consent to contact their GP. Evidence of treatment summaries being emailed to people's GPs was seen. The electronic prescriptions were non-modifiable, and each prescriber had their own login credentials for the online prescribing platform to ensure electronic prescriptions were valid. Ongoing monitoring of treatments was carried out to ensure that people's treatment was well managed, and that continuation of treatment was appropriately assessed. For example, the pharmacy contacted people who had received weight-loss treatments to assess progress and to check their BMI. The prescribing platform was programmed to automatically email questionnaires to people. Periodical reviews were seen, for example, there was evidence to show that people who had received supplies of Saxenda had been sent a questionnaire at week four, eight and 12 of their treatment. And people using Champix were contacted one month after starting medication to monitor how their attempt to stop smoking was progressing. The pharmacist reviewed the questionnaires and updated the person's PMR. The GP lead confirmed they continually reviewed and updated the assessment questionnaires on an ongoing basis. For example, people requesting treatments for long-term conditions were asked if their own GP had carried out a review in the past six months. They had to show details of the review to provide confirmation. They were advised to see their own GP if they were unable to provide evidence. For example, evidence of blood tests were needed every six months before supplying testosterone. Requests for treatment were rejected if the results were borderline. The prescribers signposted people to their own GP for ongoing monitoring or for certain biochemistry results before the pharmacy would provide further treatments. The pharmacy had updated the guidelines for the supply of Saxenda and orlistat medication. This was in response to requests from people with a BMI of 28 or less. In some instances, this was due to a person's own GP refusing to prescribe further supplies and people wishing to continue treatment even when their BMI was less than 28. The prescribers emailed or spoke to people on the phone to explain why requests were rejected. The pharmacy had updated the guidelines for supplies of erectile dysfunction medication. This was due to people's own GP refusing to issue prescriptions due to a change in their medical eligibility. The prescribers sometimes asked people to provide evidence of recent prescriptions within the last month before authorising supplies. The pharmacy informed the person's GP about rejections and the reason why they refused to supply medication, such as for over ordering. The pharmacy monitored supplies of P medicines and highlighted those products that were liable to misuse. This included laxatives and codeine-containing medications. Extra postcode checks had been introduced to identify individuals that tried to circumvent the pharmacy's medicines sales protocols. The pharmacy had controls in place to automatically block requests and it provided evidence of many rejections due to requests failing to comply with the pharmacy's policies and restrictions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy used a robot to dispense medicines in individual pouches to support compliance. A service contract was in place to mitigate the risk of breakdowns. The Scotland based engineer was able to carry out checks and repairs from a remote location. They had been at the pharmacy two weeks before to provide on-site training. The pharmacy used passwords to restrict access to people's information. For example, the dispensers had access to prescription information only. And pharmacists and prescribers had greater access to patient's medication records. Access was controlled through the use of passwords. The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.