

Registered pharmacy inspection report

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

Pharmacy reference: 9011287

Type of pharmacy: Internet

Date of inspection: 31/01/2023

Pharmacy context

This is a distance selling pharmacy in Glasgow. The pharmacy premises are closed to the public, and people access the pharmacy's services through its website, www.simpleonlinepharmacy.co.uk or by telephone. Its main activity is dispensing for its private Online Doctor service which prescribes treatment for a wide range of conditions. These include weight loss, erectile dysfunction, hair loss and skin conditions. The pharmacy sells some over-the-counter medicines via its website. It also dispenses NHS prescriptions as a pharmacy hub for the company's two community pharmacies. And it dispenses some medicines in compliance packs to help people take their medicines properly. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

Overall inspection outcome

✓ Standards met

Required Action: None

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

Summary of notable practice for each principle

| Principle | Principle finding | Exception standard reference | Notable practice | Why |
|--|-------------------|------------------------------|------------------|-----|
| 1. Governance | Standards met | N/A | N/A | N/A |
| 2. Staff | Standards met | N/A | N/A | N/A |
| 3. Premises | Standards met | N/A | N/A | N/A |
| 4. Services, including medicines management | Standards 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 suitably manages the risks with its services, including for the online prescribing service. It has documented procedures for team members and prescribers to follow to help make sure people receive medicines suitable for them to take. And it completes reviews of the effectiveness of these procedures to help keep its services safe. The pharmacy keeps the records required by law and team members keep people's private information secure. It has adequate processes to help team members protect vulnerable adults and children.

Inspector's evidence

The pharmacy used electronic 'standard operating procedures' (SOPs) to define its dispensing processes and governance arrangements. This included dispensing for compliance packs, including pouches. And team members signed paper records to confirm they had read and understood the procedures after the annual review.

The pharmacy had recently reviewed and improved its clinical governance arrangements following the appointment of new senior team members, including a new chief operating officer. This included the introduction of a new systematic approach to risk assessment and risk management across the whole organisation. At the time of the inspection, the pharmacy was in the process of changing its service model. And it had carried out a risk assessment and had identified risks and necessary mitigations to manage service disruptions. The pharmacy had completed risk assessments to identify and manage the risk of providing services online and it had defined control measures in place to mitigate these risks. Risk assessments were available for each service it provided. And a selection showed they were detailed and reflected a treatment overview of the condition. They were informed by UK national guidance such as the National Institute for Health and Care Excellence (NICE) and referenced training and support materials for prescribers. This helped ensure a uniform approach to prescribing decisions.

The pharmacy's clinical governance team included the 'superintendent pharmacist' (SI), the regular 'responsible pharmacist' (RP), the four prescribing GPs, a 'pharmacist independent prescriber' (PIP) and a clinical pharmacist. The team carried out annual reviews of the risk assessments and reviewed them earlier if prompted by a service change, such as the introduction of a new medicine. The pharmacy had recently introduced a new clinical governance log that prescribers used to document and raise any considerations or suggestions for improvements to the risk assessments. The SI who worked onsite at the pharmacy had oversight of the log and the clinical governance team reviewed the log at its regular meetings. This ensured they all agreed on any proposed changes and kept the risk assessments up to date and relevant. Risk assessments were available for each of the medications prescribed through its online service. A selection were observed, including for Saxenda, finasteride and bupropion. One of the clinical team had produced the risk assessments and the clinical lead pharmacist had reviewed them. The risk assessments considered the product licensing and restrictions for each individual medication. They were supplemented by prescribing protocols. And a selection were seen, including for asthma and antibiotic prescribing. There was some evidence to show the clinical governance team agreed not to offer medications on the website following a risk assessment. For example, Ozempic, an injectable medicine used outside of the manufacture's product license for weight loss. They had carried out a risk assessment for bupropion for smoking cessation and the team agreed

not to offer the medication for smoking cessation until they had identified and implemented mitigations to manage the risks. The pharmacy had an identity checking process for people accessing online services. It used external software to confirm the identity of people and checks included the person's name, address (billing and delivery), phone number and email where given. If the software identified a failure in the information submitted, the person was required to submit further information including a photo with their ID for the pharmacy to verify.

The pharmacy had a systematic approach to help improve the safety and effectiveness of its services. The SI was responsible for carrying out regular audits on prescribers' consultations to assess compliance with the pharmacy's prescribing policies. And the prescribers peer-reviewed a selection of each other's consultations and provided feedback and any learning points. This helped the pharmacy ensure a consistent and supportive approach to prescribing. The clinical governance team met monthly. And it documented the outcomes from the meetings and shared them with the wider clinical team. It had recently improved its communication across the organisation. And it shared relevant information with the other pharmacy teams for discussion at team huddles which took place on a regular basis every week. Discussions from these meetings included notifying GPs when people provided information on the patient questionnaire that raised concerns, such as a history of mental health. And making it compulsory to notify people's GP when prescribing asthmatic treatments. Other discussions at the clinical governance meetings had also considered and reviewed the restrictions in place for maximum quantities and duration of treatment for certain medication. This helped the pharmacy's control measures remain relevant and up to date and helped safeguard people from exceeding the restrictions before the check-out stage. When someone tried to order the same item within a certain timeframe, the order was rejected. The system also recorded information on the person's record. The pharmacy documented rejected medication requests onto people's records to inform future prescribing decisions. The RP could see this information when clinically checking prescriptions and had the ability to add notes as well. The prescribers had reviewed incidents where exceptions to the restrictions were made following peer discussions. An example was seen where the restriction of supply of the contraceptive pill was temporarily lifted for one patient who required an early supply for holiday. The clinical governance team had carried out a risk assessment for supplying medication for long term conditions. For example, it had discussed prescribing for blood pressure and had agreed to discontinue prescribing for this condition until robust prescribing protocols were introduced to ensure supplies were safe.

The RP carried out regular documented audits of higher-risk pharmacy only (P) sales against its 'standard operating procedure' (SOP) for selling P and 'general sales list' (GSL) medicines. They completed the audits on a three-monthly cycle and checks included postcodes for people ordering items for the same address under different names for medicines liable to abuse such as codeine containing products and sedating antihistamines. They also carried out audits of people requesting inappropriate combinations of medicines, such as weight loss injections alongside laxatives. The audit and monitoring of sales provided assurance that the pharmacy was complying with its own policies and procedures to keep people safe. The SI provided a selection of audit results. And it showed rejection of some inappropriate orders.

The pharmacy had assessed the risks of implementing artificial intelligence to support the clinical check of prescriptions. The system was integrated with the pharmacy's electronic patient medication records (PMR) system. The SI and other key team members had discussed the risks and implemented risk mitigation measures, such as a staged roll out. Team members using the system had been trained, and initially operated the system with a simultaneous check by a pharmacist. And they had not identified any significant errors. The pharmacy had a SOP in place to help the team manage the risks of operating the system. The responsible pharmacist (RP) on duty took overall responsibility for the automated checks carried out during their period as RP. The automated technology had systems embedded to allow for ongoing risk assessment and auditing. The system checked prescriptions in batches and at the

end of each batch, the system highlighted a representative sample of prescriptions to be manually checked by the RP as part of the quality assurance check process. Since the system had been implemented, the pharmacy had not identified any clinically significant incidents following the automated checks. This included incidents and errors that had been identified after medicines had been received by people.

Pharmacy team members highlighted and recorded near miss errors they made when dispensing and assembling medicines. This included for medicines dispensed into compliance packs and pouches. Pharmacy team members explained they discussed their errors and why they might have happened at the time of each incident and at their weekly team meeting. But they sometimes did not capture this information in their records, to help inform the analysis process. The team leader analysed the data collected for patterns each month. The records available showed a significant reduction of errors for compliance pack dispensing for pouches since November 2022. The team explained that in November, there had been contributing factors to an increase in errors which included changes made to the process along with new team members. Team members had worked hard to implement new processes to improve accuracy and managers had supported them with this. Pharmacy team members also monitored and reported errors involving the robotic dispensing technology feeding back to the system maintenance engineers, so issues could be efficiently resolved with minimal impact.

The pharmacy used bar-code technology to carry out accuracy checks for dispensing and for the completion of some of the accuracy checks on prescriptions. Records showed a low selection error rate with wrong quantity being the most common error. The team leader carried out quality checks every two weeks by manually checking some prescriptions that had been checked by bar-code technology. They had not identified any anomalies. Team members provided examples of improvements they had made to minimise the risk of the same error happening again. For example, they had identified 'look alike sound alike' (LASA) risks associated with packs of sildenafil and sumatriptan. Team members had suggested the introduction of a 'sumatriptan station', which was a dedicated area for sumatriptan prescriptions to mitigate the risk and this had been effective. The pharmacy used a template report to record dispensing mistakes. This included a section to record information about the root cause and any necessary mitigations to improve safety arrangements.

The pharmacy had been receiving an increased number of complaints about its dispensing services. And the SI had carried out an investigation to identify the causes. As a result, the pharmacy was not registering new people with its dispensing services until improvements had been made. This included planning to purchase a new dispensing robot to replace the system they were currently using. And following a site visit they had selected their preferred option due to its safety profile and capacity. The pharmacy had acted following complaints about the frozen gel packs used to maintain the cold chain for some medicines. People were concerned about the stability of their medicines due to the packs being defrosted on delivery. The pharmacy had made labelling changes to the packaging so that people knew to expect the gel pack to arrive in a solid or melted state. The label also referred to regular testing that the pharmacy carried out to provide assurance that the medicine would reach the patient at a suitable controlled temperature.

The pharmacy had appropriate public liability and professional indemnity insurance policies in place which were valid until 27 May 2023. Prescribers had their own indemnity insurance to provide cover for their prescribing activities. The pharmacy displayed a 'responsible pharmacist' (RP) notice, and the RP record showed the time the pharmacist took charge of the pharmacy and the time they finished. The pharmacy kept electronic records of supplies of private prescriptions for (POM) treatments and pharmacy only medicines (P). Team members maintained 'controlled drug' (CD) registers and kept them up to date. And they checked and verified the balances every week to confirm quantities. The prescriber on duty demonstrated the system for receiving medication treatment requests and for

producing private prescriptions. Prescribing notes were completed and added to the system. And this information was available to all prescribers for future reference.

The pharmacy was closed to the public and only authorised persons were granted access. A data protection policy was available for team members to refer to. And team members understood data protection requirements and how to protect people's privacy. They used designated containers to safely dispose of confidential information. And access to people's personal information was password protected. Each team member had their own personal log on credentials which was dependent on their roles and responsibilities. This ensured they only accessed relevant information to carry out the tasks they had been authorised to. For example, the RP accessed and approved requests for P medicines. But they were unable to access any requests for prescriptions for POM treatments which was restricted to prescribers. The 'patient care team,' did not have access to the 'summary care records' (SCRs) or the clinical mailbox. This meant they referred to the 'clinical administration team' for some queries. The pharmacy had an identity checking system in place which included age-verification to help safeguard children and vulnerable people from inappropriate supplies. And the pharmacy's auditing and monitoring arrangements identified frequent requests and requests for combination products that were not appropriate and could indicate a potential safeguarding concern. This included for weight loss such as weight loss injections and laxatives. The pharmacy had trained the patient care team on how to manage calls from people that may present as suicidal.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And the pharmacy is good at supporting its team members ongoing learning and development needs. The pharmacy reviews its staffing levels in line with changing workload. And it has reliable plans to cover team members absence. Team members have the opportunity to provide regular feedback. And they are proactive and suggest improvements to keep pharmacy services safe and effective.

Inspector's evidence

There had been a significant growth in the pharmacy's activity since its last inspection in 2021. And the treatments it supplied via its online prescribing service continued to account for most of its activity. The pharmacy employed a significant number of team members who worked in different teams across the organisation. The teams were managed by team leaders who met each morning to discuss pharmacy operations. They also attended a weekly meeting that had been recently introduced to improve communications across the organisation. This provided them with the opportunity to hear about organisational changes which they cascaded to their team members. It also provided the opportunity to provide feedback about areas of concern. An example of recent suggestion from team members included rearranging the workspace to create a separate dedicated area to receive orders into the pharmacy.

A pharmacy technician team leader had line management responsibility for 21 dispensers and pharmacy technicians in each of the dispensing functions. This included the dispensing of NHS prescriptions, compliance pack services and the supply of 'pharmacy only' (P) medicines. At the time of the inspection, trainee dispensers were undergoing qualification training and the pharmacy provided two hours protected learning time each week to support them. A recent staffing review had identified the need for a team member to undergo an accuracy checking dispenser accreditation to support 'accuracy checking technicians' (ACTs) in their roles. And the selection process was ongoing. Team members attended a daily huddle to plan the workload for the day. And minimum staffing arrangements across the dispensing teams permitted only two dispensers to be off at the one time.

The pharmacy used an online communication platform to support real-time communication. And teams could instantly communicate with each other when they needed to. The SI had carried out an investigation following an increase in complaints about the pharmacy's dispensing service. And they had identified that some team members in the patient care team had not been liaising effectively with other team members about prescription queries, which had led to delays. Changes had been made following this to help improve the service. The patient care team consisted of eleven team members worked in a separate dedicated area of the pharmacy. They responded to telephone calls, emails, and text messages.

The pharmacy acted as a hub dispensary for two pharmacies in the same company and they were in possession of an NHS contract. Senior team members were responsible for reconciling NHS prescription orders from these pharmacies and they also communicated with GP practices when there were missing items. The pharmacy had recently recruited three new team members, and this included a new

customer success manager to improve call outcomes and the effectiveness of the team. They monitored the queue of people who had contacted the pharmacy with queries. And they allocated workload to other team members to help manage the waiting times and to resolve issues in a timely manner to avoid delays. A regular huddle ensured team members kept up to date with the requirements of their roles and responsibilities.

Patient care team members were not required to complete qualification training, due to their roles. They completed data protection and safeguarding vulnerable people training as part of their induction to help ensure they had the skills to carry out their roles. This included responding to queries and managing prescription requests. They read the SOPs and relevant processes they were expected to follow. A clinical administration team worked alongside and supported the patient care team. The team included the RP, a second pharmacist, the pharmacy technician team leader, a pharmacy graduate, and a trainee pharmacy technician. The patient care team members knew to refer to the clinical administration team to help with complex queries and complaints. A new team member who was about to register as a pharmacy technician had recently taken up post in the clinical administration team. They had completed the pharmacy's induction procedures which included a session with the RP who explained the pharmacy's services and the differentiation between a conventional community pharmacy and an online pharmacy with a prescribing service. The new team member was responsible for dealing with clinical queries and registering new people who wished to receive their medications in compliance packs. They worked under the supervision of a pharmacist, and they knew to refer to a pharmacist out with their level of competence.

Team members completed ongoing mandatory learning ad hoc when sent to them by their managers. These also included any new or updated standard operating procedures (SOPs). They also regularly discussed learning topics informally and the pharmacist highlighted topics for team members to learn more about. They were provided with time during working hours to complete their training. The pharmacy carried out a formal appraisal of performance with the team members once a year. They completed a self-evaluation questionnaire before the appraisal and scored themselves in how competent they were at carrying out various areas. The team members' manager also completed a questionnaire for the team members they managed. This informed the discussions and identified learning and development needs. And team members set objectives to work towards. A team member provided an example of a recent objective. They had re-evaluated the processes they followed to manage prescriptions for people who received their medicines in a compliance pouch system. And they described how they had successfully changed the system to make it more efficient to manage the increase in demands. They provided training for the other team members with support from their colleagues and managers to evaluate and implement the new procedures.

The pharmacy employed four GMC-registered doctors to provide its online prescribing service. The SI managed the prescribing team, and they had recently recruited the fourth doctor due to increased service demand. This ensured they were able to effectively manage the workload demands. One doctor at a time provided cover with doctor colleagues providing support when it was busy. This ensured they reviewed all the consultation assessment forms by the deadline each day. The pharmacy had recently appointed a 'pharmacist independent prescriber' (PIP), but they had not yet been providing prescribing services. The doctors worked part time and practiced in other areas such as general practice which also ensured they kept their knowledge up to date. There was flexibility between prescribers to cover both scheduled and unplanned absences to ensure business continuity. And there was an open and honest culture with the opportunity for prescribers to input into prescribing procedures and risk assessments.

Prescribers completed ongoing revalidation to comply with the requirements of their professional body. There had been a training session to support the pharmacists and the prescribing doctors with the delivery of a safe and effective weight management service. The prescribing team had identified the

learning objectives for the session which included consideration of the availability of new medication, goals of treatment and when it was appropriate to stop treatment. And they used the learning outcomes to inform the RAs for the weight management service. The prescribing team utilised an online communication platform to seek help and guidance from their prescribing team colleagues. They also used the platform to highlight any new guidance or research that would benefit each other. The SI and the clinical lead pharmacist had introduced a prescribing competency record. This was used to support the annual performance review process for prescribers which included recording information about the prescriber's experience, training, specialism, and limitations of practice. A process for escalating prescribing decisions that was beyond prescriber competence was in place. The prescribing doctors were salaried employees, and the pharmacy did not provide incentives for them to produce prescriptions. Neither were they eligible to be part of the company's share scheme. Regular locum pharmacists worked at the pharmacy, and they had developed the necessary knowledge of online pharmacy operations to safely work there. The RP was responsible for reviewing and updating the pharmacy's locum guide for team members to refer to.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are large and are suitable for the services provided. They are clean, hygienic, and secure. The pharmacy's website looks professional and provides ease of access for people to use.

Inspector's evidence

People accessed private services online through the pharmacy's website. The website displayed the voluntary GPhC logo. And it provided details about the owners, its physical location and contact details. It also provided the names and the registration details of the SI and the prescribing doctors. Prescribing consultations were undertaken via the company's website. The consultation was questionnaire based and the system prevented people changing their answer when a negative response was provided. This helped to manage the risk of people receiving a medication that was not suitable for them. The website's layout was clear. It provided information on treatments, and consultations were started from the conditions page.

The pharmacy was in large, modern purpose-built premises which provided ample space for its services. Team members kept the areas neat and tidy and free from congestion. And they were organised and free from slips, trips and falls hazards. Team members carried out their roles and responsibilities for each of the services in well-segregated areas over two floors. A series of dispensing benches on the ground floor provided for dispensing with a separate bench used for compliance packs. The mezzanine floor was well-organised with areas for the assembly of 'pharmacy only' (P) medicines and the dispensing of private prescriptions and medications into compliance pack pouches.

Team members operated an automated system for some dispensing. It was situated in a separate area alongside a bench for assembly and checking activities. 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. And lighting and the ambient temperature were adequate throughout. Staff rooms and toilet facilities were located on the ground floor and a seated outdoor area was also available for team members to use. A reception area and well-equipped offices were at front of the premises. And these provided suitable areas for activities that required safeguards to manage confidentiality. There was the use of a dispensary sink for hand washing and professional activities. And team members cleaned and sanitised the pharmacy on a regular basis. Hand washing arrangements were also available in the toilet. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. 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 separate dedicated area was used by the patient care team. Sound-proofed workstations ensured that telephone conversations were carried out in private.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has sufficient safeguards in place to help ensure people receive medicines that are suitable for them to take. And it uses automation to help manage the delivery of its services effectively. The pharmacy manages its medicines appropriately and stores them properly. Team members carry out checks to make sure medicines are in good condition and suitable to supply. The pharmacy makes its services accessible to people through its website. And it makes changes when it identifies some people experience delays to accessing services and receiving their medicines.

Inspector's evidence

People accessed the pharmacy's services via its website, and it provided information about its online prescribing service and how to use it. It also included information on the conditions and treatments available. The website included a link to an NHS website which signposted people to more information about conditions, symptoms, and treatments, and what to do and when to get help. People contacted the pharmacy by telephone and text messaging. A patient care team of around 11 team members handled the communications sent to the pharmacy from Monday to Saturday. And they arranged for a pharmacist to contact people when queries were out with their level of competence. The pharmacy did not keep records of these telephone consultations in the patient notes on the PMR to help inform decisions for future supplies. Half of these team members were also responsible for reconciling NHS prescriptions and liaising with GP practices for missing items. They knew to call on the team leader if they needed help to manage the workload of queries. And they knew to change the status of the communication to 'pending' whilst they awaited replies to queries. Recently this process had led to significant delays with some people not receiving a response and sometimes causing them to go without their medications. The pharmacy had made some recent changes and appointed a new customer care team manager to oversee the process and provide additional support. A team leader monitored the queue of workload and arranged for other team members to provide extra support to manage the queue when required. The NHS clinical administration team consisted of the RP, a second pharmacist, the pharmacy technician team leader, a pharmacy graduate, and a trainee pharmacy technician. The team was on hand to support the patient care team with non-routine tasks, complex queries, and complaints. One of the patient care team members provided examples of dispensing mistakes which people identified after they received their medicine. And how these were forwarded to the clinical administration team for investigation.

People completed an online consultation questionnaire to access the pharmacy's private online doctor prescribing service. And one of the GP prescribers reviewed it before authorising a prescription. Access to the platform required two-factor authentication and there was an electronic audit trail of which prescriber authorised a person's treatment. The pharmacy's software had safeguards in place to prevent incorrect dosing on prescriptions. For example, the dose for providing doxycycline for malaria prophylaxis could not be inputted following a consultation for chlamydia. The pharmacy's system applied a rating depending on the answers people provided and prescribers considered this in their decision to prescribe. They sometimes contacted people directly to discuss a request or when they needed further information to make a prescribing decision. They made a record on the system as to the action taken. An example was seen for asthma treatment when the prescriber had requested more information which provided evidence to show the treatment was suitable. They clearly documented the

intervention before prescribing the treatment. Examples of prescribers signposting people to further information about their condition was seen. This meant people were able to access further relevant information about the condition they were being treated for. Prescribers and pharmacists using the system had access to view records of both prescription-only-medicines (POMs) and P medicines sales provided by the pharmacy. Records of any previously rejected requests were also visible. When people failed to respond to requests for more information, then the order was seen to be rejected.

The pharmacy had a review process in place for certain conditions and treatments. Prescribers had specific criteria required for people requesting asthma treatments which included reviewing symptom control and to make sure they were appropriately monitored by their own GP. It had policies restricting supplies of inhalers and prescribers were able to show examples of prescriptions rejected as they were requested too frequently. Consultations for asthma relied on the information that people inputted, due to the pharmacy not having access to summary care records and not asking for evidence of review by their usual GP before prescribing. The person's usual prescriber was informed of any supplies so people's condition could be monitored. Any feedback from these prescribers could be used to help with future prescribing decisions.

The pharmacy required people requesting weight loss medications to provide their current weight at each consultation. The patient medication record (PMR) showed previous values which the prescriber reviewed. This allowed them to measure progress and determine if ongoing prescriptions were appropriate and safe. Examples were seen where the prescriber had contacted people when weight loss was not as expected after 12 weeks. Contact was made either by telephone or video call. They kept notes of the consultation on the PMR. People were provided with an email link and physical QR code at each supply directing them to a support pack for using weight loss medication. This provided both written and video information to support people using injected medication. Records viewed during the inspection indicated that supplies were appropriate with records of additional information and advice given to people. Physical examination, face-to-face consultation or compulsory sharing information with the person's usual GP was not part of the process when prescribing weight loss products. But they asked people for additional information such as their daily calorie intake and exercise habits. People receiving prescriptions for weight loss injections were advised not to obtain supplies elsewhere to keep them safe. And the pharmacy's online consultation questionnaire strongly advised people to inform their GP of any treatment received.

The RP carried out a clinical check before team members dispensed prescriptions. And they referred to a full view of the person's consultation record. This included a history of supplies, rejected requests, medical conditions, prescriber notes and compliance with prescribing policies. The system recorded the RP's name and registration number for the clinical check. Team members generated labels for dispensing once the prescription had been clinically checked. The PMR system did not have the facility for an automated check of interactions between medications. But this had been considered as part of the risk assessment. And the pharmacy's formulary provided a list of the medications that were available via the online doctor service and their interactions. The pharmacist referred to this as part of their clinical check. The RP discussed prescribing decisions and challenged and discussed potentially inappropriate prescriptions when they had justification to do so. The pharmacist added relevant notes to the PMR. Records showed when medicines that were not clinically appropriate were refused or referred back to the prescriber. The patient care team kept notes of verbal and written communications when people contacted the pharmacy. And team members referred to the records when people had queries about their medication, or they wished to raise a complaint. The system used by the patient care team operated independently and was not connected to the PMR.

The pharmacy acted as a hub, dispensing NHS prescriptions for two pharmacies in the company. Clinical checks for prescriptions were managed in the PMR system, and the automated system meant not all prescriptions were identified as needing a pharmacist's direct intervention each time. Prescriptions for a pharmacist were placed in a queue and managed in batches. Once the clinical check was complete they were released to the next stage. Prescriptions required a pharmacist's intervention for various reasons. These included invalid prescriptions, prescriptions for children under 12 years old, and irregular doses and quantities. It also included higher-risk medicines such as warfarin and methotrexate, controlled drugs including any codeine-containing products, interactions with other medicines, and prescriptions for people where special notes had been added to their records, for example where they required a specific brand of a medicine. The pharmacy was unable to change these exclusions which were embedded into the system. But it was able to add exclusions to help the pharmacy manage locally identified risks. The clinical automation system required the pharmacist to manually check prescriptions where medicines had been prescribed or dispensed to someone for the first time. If someone's medicines were stable and their prescriptions were not highlighted for any of the pre-defined exclusion criteria, then prescriptions would bypass a pharmacist's intervention. Some prescriptions from this group were selected as a random sample of prescriptions for quality assurance checks after each batch. This meant there was a small residual risk of some people's prescriptions, whose treatments were stable, to be dispensed for an undefined period without intervention by a pharmacist. The pharmacy also had various systems in place to identify overprescribing and oversupply of medicines. This included automated and manual systems at various stages of the dispensing process.

Team members managed dispensing tasks well. They used different coloured dispensing baskets during the assembly and labelling process to keep people's medicines and prescriptions together and to avoid the risk of errors. For example, they used a different coloured basket if there was an item out of stock that needed to be added later. The pharmacy used automation for the dispensing of compliance packs in pouches. Team members transferred medicines from original manufacturer's packaging into amber bottles, labelled with details that included the manufacturer, the batch number, and the expiry date of the medicines. Each medicine contained a QR code, which when scanned on a device, linked to the medicine's patient information leaflet. This provided team members with the option to print a leaflet and to obtain an accurate description of the medicine to help with identification. Pharmacy team members explained they only transferred medicines that they had stability data for, and they limited the quantity transferred. Team members transferred medicines into canisters for dispensing and these were loaded into the system for dispensing of the pouches. The canisters contained desiccants to help prevent moisture and maintain the stability of each medicine. The system manufacturer provided information about medicines that had been removed from the manufacturer's original packaging. And this helped the team identify medicines that were not suitable to be dispensed in this way. Access to the system was restricted to authorised and trained members using unique passwords and fingerprint scanning. This helped to keep an audit trail of who had accessed the system and who had filled each individual canister. The base of the canister was a unique shape and contained a unique barcode. This meant it could only be placed in the system in one location. Team members scanned barcodes, including the barcodes on packs of medicines and stock containers to help prevent mistakes. Not all medicines were dispensed from the canisters. Pharmacy team members manually added some medicines to the system's removable tray to be dispensed into pouches from there. A pharmacist carried out an accuracy check of each medicine after a dispenser added them to the tray. After the medicines were dispensed into pouches, the pharmacy used photographic identification technology to scan the medicines in each pouch. The pharmacist completed a manual, visual check of any pouch that the system highlighted as having a potential inaccuracy or anomaly. Once completed, team members transferred a person's pouches into a box and attached dispensing labels so people had written instructions of how to take their medicines. They included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Each pouch also displayed printed information about its contents,

including the name and quantity of each medicine, the day, date, and time the medicines should be taken and the person's details.

The pharmacy received private prescriptions from services other than the online doctor service. A private dermatology service submitted prescriptions including for the higher-risk medication isotretinoin. This medication was subject to a pregnancy prevention programme due to the risks in pregnancy. The pharmacy ensured that the result and date of a negative pregnancy test were present on each prescription received from the clinic. The pharmacy team members were aware of the pregnancy protection programme with valproate and the risks to the unborn child.

The pharmacy used a postal service and a national courier service depending on people's requirements and the medications that were being delivered. The pharmacy had arrangements to provide assurance that cold-chain items were transported at the correct temperature. These items were packed in boxes containing cold packs and insulating materials. Packages were clearly labelled as cold-chain items. And they were dispatched using a tracked service. The pharmacy regularly monitored the integrity of cold-chain packaging by dispatching a package to selected addresses across the UK containing a monitoring device. The monitoring device transmitted temperature information in real time to the pharmacy so they could confirm the package contents had been maintained at the expected temperature. The pharmacy increased the frequency of the checks over the summertime. The pharmacy had multiple suppliers for packaging materials to manage the risk of one supplier being unable to supply.

The pharmacy supplied P medicines, ordered through its website. People answered questions about their health and medication history at the time they placed orders for P medicines. The RP checked the orders to confirm supplies were appropriate. This included assessing the potential for misuse or abuse to help safeguard vulnerable people. The clinical team regularly reviewed the maximum quantities and durations allowed for P medicines.

Team members kept stock neat and tidy on a series of shelves. And they used two large fridges to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. A large freezer cabinet kept the ice packs that were used to keep refrigerated items at the correct temperature during transportation to people's delivery address. Team members carried out monthly expiry date checks of all medicines, including medicines dispensed from the automated dispensing robot. They updated records to keep track of when checks were next due. The pharmacy received notifications of drug alerts and recalls. And team members carried out the necessary checks and knew to remove and quarantine affected stock. The pharmacy had medical waste bins. And this supported the pharmacy team to manage pharmaceutical waste.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has a range of equipment available to help provide its services effectively. And its team members know how to clean and maintain it.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources. And separate private offices could be used to hold confidential discussions with people that contacted the pharmacy. It used cleaning materials for hard surface and equipment cleaning. And a dedicated team member carried out cleaning and housekeeping tasks every day. The pharmacy used counting triangles in the event it needed to split packs and provide a specified number of doses. And it had procedures to clean the dispensing system it used to dispense some medicines into pouches. A service contract was in place to mitigate the risk of breakdowns. And the pharmacy had access to local maintenance engineers who they contacted if the system failed. The engineers were usually available to respond and attend the pharmacy within hours. This managed the risk of delays with people receiving their medication. The manufacturer had provided an instruction manual and trained the team members to properly maintain the equipment. This included instructions about how often to clean the various parts, and what equipment to use. Cleaning tasks were divided into daily, weekly, monthly, and quarterly tasks according to the manufacturer's schedule. And team members kept records to show these tasks had been completed. The manufacturer serviced the dispensing robot every year. The pharmacy used discreet packaging for deliveries. This meant that people were unable to identify the medicines that were contained within.

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. |