General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dermatica, Unit 7, Datapoint, Cody Road, London, E16 4TL

Pharmacy reference: 9011448

Type of pharmacy: Internet / distance selling

Date of inspection: 08/09/2023

Pharmacy context

This is a distance-selling pharmacy located within a large industrial unit in East London. The pharmacy dispenses unlicensed topical medicines which it prepares on site for various skin conditions. The pharmacy uses pharmacist independent prescribers (PIP) to prescribe these preparations. The prescribing service is not registered with the Care Quality Commission (CQC). The pharmacy carries out research and new product development.

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	2.2	Good practice	Team members have the appropriate skills and qualifications for their roles. The pharmacy supports its staff with ongoing training, and they get protected time at work to complete it.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website is arranged so that a person can select a prescription only medicine (POM) before stating a consultation with a prescriber. And the website contains some information which might mislead people about the prescribers and their treatment.
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 generally manages risks to make sure its services are safe, and it acts to improve patient safety. It audits and reviews its prescribing service to make sure its processes are safe and effective. And it generally keeps it's records up to date. Members of the pharmacy team are clear about their roles and responsibilities. The team has written procedures about keeping people's private information safe. And on the whole, team members understand how they can help to protect the welfare of vulnerable people. But the pharmacy could do more to highlight the potential risks of using unlicensed medicines to people and to make sure people are who they say they are.

Inspector's evidence

The pharmacy compounded and supplied topical medicines mainly for the treatment of acne, ageing, melasma, hyperpigmentation and rosacea. The medicines were prepared under section 10.1 of the Medicines Act 1968. The pharmacy was not regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). This meant the medicines did not hold a UK marketing authorisation or registration and were unlicensed. Therefore, the medicines had not been formally assessed through the licensing process for safety, quality, and efficacy. The unlicensed nature of medications was explained to patients in an acknowledgement when an order was placed. But there was no information on the website or in leaflets provided by the pharmacy. So, there was a risk that people may not understand that they had been prescribed an unlicensed medicine, and the risks associated with this.

Between 90-95% of the medicines supplied were against prescriptions issued by pharmacist independent prescribers (PIPs) at the pharmacy's online prescribing service. People accessed this service via the pharmacy's website www.dermatica.co.uk. This was a remote prescribing service and people were not seen face-to-face. The medicines contained combinations of ingredients some of which were prescription only medicines (POMs) such as tretinoin, adapalene, clindamycin and metronidazole. People were generally asked to select their condition, and then complete an online consultation and upload at least three photographs of themselves which showed the condition to be treated. Some over-the-counter products were supplied for example moisturizers, cleansers, or clarifiers. People could select these and go straight to the checkout without a consultation. Medicines were delivered to people living in the UK and some European countries using a Royal Mail service which could be tracked.

People were required to set up an account when they started using the pharmacy's online services. The pharmacy operated a subscription model so people received monthly supplies once they had signed up. The pharmacy's IT system had multiple-account recognition and automatically flagged up duplicated information, such as post codes or telephone numbers. This helped prevent people creating multiple accounts and a team member would email the person to obtain further information or block the account if necessary. A person's previous order history was checked when reviewing a consultation to make sure any inappropriate requests were identified. People were asked their age as part of the process, but their age and identity (ID) were not verified, so this there was a risk people could provide false information to obtain medicines. The prescriber compared the person's name, sex, and date of birth to the photographs that the person had uploaded. If the prescriber felt the need to confirm anything, such as their age, they contacted the person and requested proof of their ID. The pharmacy

had carried out an internal review of their ID policy and felt that the risk of somebody not providing genuine ID details such as the correct age was very low, as none of the medicines were liable to abuse or misuse. And the pharmacy lead explained that a person's skin could not tolerate multiple products or excess use of products.

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided, with signatures showing that members of the team had read and accepted the SOPs relevant to their roles. Roles and responsibilities were set out in SOPs and team members were performing duties which were in line with their roles. The superintendent pharmacist (SI) was working as the responsible pharmacist (RP). A different name was displayed on the RP notice in the pharmacy and on the pharmacy's website at the start of the inspection, which might confusion in the event of a problem or query, and this was not in line with the RP requirements. The SI printed off an RP notice with his name on it and displayed it when this was pointed out.

Dispensing errors and near miss errors were reported and reviewed at monthly patient safety meetings by senior members of the pharmacy team including the dispensary manager and the SI. Learnings were shared with relevant team members. All the medicines supplied by the pharmacy were in very similar packaging which could increase the risk of errors. However, the pharmacy lead stated that errors were minimal as there were four stages in the dispensing process, each carried out by a different member of the team. Any errors identified during these stages were recorded as near misses, so the team could learn from them. The dispensary manger recently carried out a near miss audit which led to the introduction of an additional step that the RP or accuracy checking technician (ACT) recorded the batch size in which the near miss occurred to help determine whether the near miss was across a whole batch or mixed within a batch. The pharmacy lead explained that following the audit the importance of thorough checks at every stage of the process was re-iterated to the team.

The pharmacy had risk assessments for all products that the pharmacy prescribed. And each risk assessment included consideration of the risks associated with prescribing remotely. The clinical risk assessments were developed by the clinical lead with input from other members of the clinical team. Prescribers read and signed these risk assessments and added them to their personal declarations of competence. The risk assessment for tretinoin assessed the risk in pregnancy as 'very low.' The online consultation asked people if they were pregnant. If they answered yes, the prescribing system did not offer treatment options such as those containing tretinoin. So, prescribers were not able to prescribe medicines which the pharmacy assessed as unsafe in pregnancy if a person had indicated they were pregnant. However, the responsibility was placed on the person ordering treatments to advise if they were pregnant or breastfeeding for any subsequent order. This could create a risk of pregnancy not being highlighted before supply of medicines which are potentially unsafe in pregnancy. For example, tretinoin. However, the pharmacy had taken steps to help mitigate this risk, for example by providing treatment guides and giving people regular notifications to remind them to update their medical information. There was a risk assessment for staff members, and those who were pregnant or trying to become pregnant were not allowed to come into contact with tretinoin, to reduce the risk of any teratogenic effects.

The pharmacy had clinical protocols for all treatment pathways. And these outlined what treatments were available for each condition treated. The clinical lead explained these were developed with reference to national guidance, including that published by the British Association of Dermatologists (BAD) and the National Institute for Health and Care Excellence (NICE). These were approved by the medical lead for the pharmacy, who was a registered medical dermatologist. A sample of protocols were reviewed following the inspection, and they contained references to national guidance and primary research. The clinical protocol for acne stated that 'Pregnancy, breast feeding and trying to conceive are contraindications to Tretinoin, Adapalene and Hydroquinone at Dermatica.'

The pharmacy had a process to audit every prescriber's consultation notes monthly. Each prescriber had random consultations audited against set standards and a quality score was generated. The pharmacy's clinical lead had access to a dashboard which highlighted each prescriber's approval and prescribing rate. A high approval and prescribing rate were flagged for investigation as the pharmacy recognised that not all requests for treatment were clinically appropriate, therefore there should be a percentage of rejected requests. This dashboard was checked weekly by the clinical lead. Every month, the clinical lead discussed audit results with team leads and highlighted trends and areas for improvement. These insights sometimes triggered training sessions. And feedback was provided to each prescriber. Examples of development plans for some prescribers were reviewed following the inspection. And these highlighted how prescribing could be improved.

There was a customer complaint SOP. The pharmacy's website included details about how to make a complaint. People could contact the customer care team by completing a form in the 'contact us' section on the website. People were able to review and rate the pharmacy on various platforms, such as Trustpilot. Complaints and significant adverse events were documented on an electronic log, which consisted of different sections so the team could track the movement of the incident, from assigning and investigating, to closure. If there was an incident such as somebody reporting texture changes to their preparation, they were asked to send the product back to the pharmacy for testing. If batch errors were identified, then the customer care team contacted other people who had received a medicine from the same batch. Serious drug reactions were reported through the Yellow Card Scheme (YCS) but if the reported reaction was a normal side effect, such as mild stinging or burning, then these were documented on an 'issues log' but not reported through the YCS. Queries and concerns of a clinical nature were escalated to the clinical team for investigation. The pharmacy had a system to identify and investigate prescribing errors. One example given was when the pharmacy identified a trend of adverse reactions to a treatment. As a result, the clinical team developed an allergy SOP for providers to help identify those at increased risk of allergic reactions to treatments. Incidents and complaints were discussed with prescribers where required.

The RP log was generally in order. Controlled drugs (CDs) were not supplied from the pharmacy and there wasn't a CD register. Each prescriber had an individual login to the prescribing system. And prescriptions could only be generated and authorised by the pharmacy's prescribers as only prescribers had the functionality to prescribe. And changes or additions to a person's clinical record were logged by the individual prescriber's login details. Each prescription was signed by a prescriber using an advanced electronic signature. This was visible at the bottom of the prescription form. The prescriptions were sent electronically to the pharmacy and the prescriptions could not be edited after the point of prescribing. The private prescription register was electronic and was in order. The pharmacy maintained electronic consultation notes for people it prescribed treatment to. And these were linked to the electronic record for each person. Photographs and the online consultation were included in people's clinical record. As well as a record of any comments and queries. All prescriptions were logged on the person's record. And the RP, SI and other prescribers had visibility of the prescriptions and patient record. So clinical information relating to the persons prescription was visible to those who needed access to it. The pharmacy had regular backups of servers. There were Control of Substances Hazardous to Health (COSSH) records available. The SI confirmed that the pharmacy had current professional indemnity and public liability insurance and that it covered all the activities carried out at the pharmacy, including independent prescribing, and compounding unlicensed medicines.

Members of the team had completed training on the General Data Protection Regulation (GDPR), handling patient information and record keeping. Computers were password protected. A dispenser correctly described the difference between confidential and general waste and explained that confidential waste was shredded. The pharmacy's privacy policy was available on the website.

Team members had completed training on safeguarding according to their role. The prescribers, pharmacists and pharmacy technicians had completed level three training on safeguarding in adults, but there was no specific evidence of training on safeguarding in children for the prescribers, despite the clinical protocols stating treatments were available for people aged 16 years. Following the inspection, the clinical lead confirmed that the prescribers would complete safeguarding training on children as a priority. The contact details of the local safeguarding team were displayed in the pharmacy. The SI explained that if a safeguarding concern was outside for a person outside the local area, a team member would look up the relevant details.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are well trained, and they work effectively together. The pharmacy encourages them to keep their skills up to date and supports their development. And they get protected training time at work. They are comfortable providing feedback to their manager and they receive feedback about their own performance. Team members have opportunities to discuss issues and they communicate well. The pharmacy enables the team members to act on their own initiative and use their professional judgement to help people who use the pharmacy's services.

Inspector's evidence

The pharmacy's staff were in separate teams which included the dispensary team, the clinical team, the compounding team, and the customer care team. The clinical team and customer care team worked remotely, and the dispensary and compounding team worked on the pharmacy premises. The pharmacy used an electronic messenger system to communicate between the teams. The dispensary team was managed by a qualified dispenser and there was a regular pharmacist based in the dispensary. Neither of these staff members were present at the inspection. In addition to the SI, there was an ACT and around twelve qualified and trainee dispensers on duty in the dispensary at the time of the inspection. There were also two new assistants who were not enrolled onto a dispensing course, but they were only involved in packing and dispatch tasks. The staffing level was adequate for the volume of work during the inspection. Absences were covered by re-arranging the staff rota and locum pharmacists, ACTs and dispensers were used when necessary. There was a pharmacy lead who was present for most of the inspection. She was a pharmacist and worked between the two pharmacies in the building. There was a warehouse team which worked between both pharmacies.

Ongoing training was provided for the dispensary team and training records were maintained including new team member's induction. Certificates were on display of the dispenser's qualifications. Members of the team on dispensing courses were given half an hour protected training time each week. Performance reviews were conducted with all permanent members of the team every six months. Informal meetings were held where a variety of issues were discussed, such as new products to be launched. Details of these meetings were not usually recorded, so there was a risk that any issues raised might not be addressed. A member of the dispensing team confirmed that there was an open and honest culture in the pharmacy and said she would raise any concerns with her line manager. She was comfortable admitting and discussing errors and felt that learning from mistakes was encouraged. There was a whistleblowing policy.

The SI was empowered to exercise his professional judgement and could comply with his own professional and legal obligations. He said he raised any clinical issues which he had with the prescribers and could refuse to supply a medicine if he felt it was inappropriate. He said in these cases he would refer the person to their own GP or the clinical team. The SI said that the only target which was set was to supply 90% of all medicines on the same day that they were prescribed.

There was an ACT and two production line operators working in the compounding unit. All members of the compounding team had completed a manufacturing course and a compounding course. The manufacturer of the mixing machines also provided training to the team. The operators all had degrees

in a scientific field, such as biochemistry, and had been provided with in house training. The SI had a PhD in skin formulation and had worked in an aseptic unit at a hospital and in production at a pharmaceutical company. He kept up to date by reading a compounding journal. He had also completed training in quality assurance procedures.

One or two members of the customer care team were qualified dispensers, but most of the team including the manager did not have a background in pharmacy. The pharmacy lead confirmed that team members completed in-house training and referred any clinical queries to the clinical team. They knew not to advise outside of their competence.

The clinical team consisted of pharmacists, dermatologists, doctors, and nurses. During the inspection, a video call was arranged with the clinical lead and the clinical operation manager, who were both registered pharmacists. The clinical lead had worked for the pharmacy for around a year and explained that they oversaw the pharmacy's 35 prescribers. She felt this was sufficient to manage the demand on the service without adversely impacting patient safety. The clinical lead explained there were contingency plans in place in case of a surge in demand. And this included asking some prescribers who worked part-time to work additional hours if needed. The pharmacy carried out annual appraisals for prescribers. And there were mid-year performance checks. There was a bespoke competency framework for prescribers which outlined the skills, knowledge and behaviours expected of prescribers who worked for the pharmacy. And it outlined how competency was measured and checked through audits and assessment. The pharmacy's Human Resources team checked the professional registration and prescribing qualification of all prescribers on appointment. And prescribers maintained a declaration of competence statement which outlined what clinical areas they were competent to prescribe in. The pharmacy developed a competency framework for prescribers to adhere to. And this set out guidance and standards relating to safe prescribing. The clinical lead explained that prescriber development needs were also identified through audits. And this was a safeguard to ensure prescribing was reviewed regularly and support offered if needed.

One of the prescribers was spoken with during the inspection and had recently been promoted to the position of team lead. They were responsible for overseeing eight to ten other prescribers. They explained that prescribers usually work on any orders which were pending clinical review. And that they could email or telephone people requesting treatments. They confirmed that protocols for each condition were available to prescribers. And that people could email the clinical team about adverse effects or concerns. The prescriber explained that the pharmacy had a supportive in-house training programme and had invited external speakers to present clinical topics to prescribers. They explained the audit process for prescribers and that there was a 95% standard for audits on consultation notes. They highlighted how email consultations were spot checked for quality and adherence to the clinical protocols. And included aspects such as language used and that a person's concerns were sufficiently addressed.

Prescribers were encouraged to work autonomously and within their professional judgement. And guidance was available to support them. The clinical lead recognised that some cases did not fall within guidance and in such cases, prescribers could make professional judgements on how to best prescribe. The clinical team leads completed spot checks on any deviation from guidance and discussed with prescribers to understand their rationale. The clinical lead explained there was a culture of learning at the pharmacy with regards prescribing. And that feedback was given freely to encourage mutual development. The purpose of feedback was to support and develop colleagues and any member of the clinical team was able to provide feedback on a colleague. The clinical lead held weekly check-ins with prescribers to check on their wellbeing. And the pharmacy sent anonymous engagement surveys to team members to check if there were any trends or issues which needed addressing.

Prescribers were able to escalate consultations to a more senior prescriber if needed. This was at the professional discretion of prescribers if they identified a case outside their scope of competence. There was a senior prescriber on-call during shifts for prescribers to seek support from. And the pharmacy had a dedicated messaging channel for prescribers to seek advice from each other. This was in addition to a knowledge base of information the pharmacy had developed which prescribers could search for if they needed to refer to guidance.

The pharmacy did not impose any financial targets on prescribers and prescribers were not paid based on the volume of prescriptions they issued. The pharmacy had a process in place to identify higher than expected prescribing rates as this could indicate potentially inappropriate prescribing. There was evidence of orders which were rejected. And this demonstrated that prescribers could refuse to prescribe when they felt it was clinically unsuitable.

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

Summary findings

The pharmacy premises provide a professional environment for the provision of healthcare services, but the pharmacy's website allows people to choose a prescription only medicine before beginning a consultation with a prescriber. This could mean that people may not receive the most suitable treatment option for their needs. The pharmacy could do more to ensure that the information on its website is up-to-date and not misleading, so people using the service are able to make an informed decision about their care. And the pharmacy needs to comply with any guidance or advice provided by any other healthcare regulators.

Inspector's evidence

The pharmacy premises were clean, spacious and in a good state of repair. They were located within a large industrial unit which also contained a warehouse and another pharmacy. The temperature and lighting were adequately controlled. The premises were cleaned daily by a cleaner. The pharmacy was not accessible to members of the public. There was a steel mesh door between the pharmacy and the warehouse, and entry was restricted by a lock which required an access code. This had been installed to prevent access by people from the other pharmacy via the warehouse. The door was open at the start of the inspection but closed and locked shortly after the start of the inspection. Some of the pharmacy's stock including POMs were stored in the warehouse and some members of the warehouse team were authorised to access to the pharmacy. The pharmacy was on two floors. There was a compounding room, laboratory and sink on the second floor. The compounding room was cleaned around three to four times a day. Areas were decontaminated with various agents, including industrial methylated spirit, isopropyl alcohol, and distilled water. Staff had access to a tea-room with a kitchen area, and two WCs, with wash hand basins and hand wash. There was hot and cold running water.

People using the website were able to select tretinoin or adapalene, which were POMs, before having a consultation with a prescriber, which was not in line with GPhC guidance. And it meant a person might receive a medicine which was not the most clinically suitable for them. The pharmacy's website contained some information about the pharmacy, but the pharmacy's phone number and email address were not displayed, so people might find it difficult to contact the pharmacy by these methods. The address of the prescribing service was not displayed, and it was not very clear who prescribed the medicines. There was a list of 12 UK registered prescribers on the website, who were all PIPs, but the clinical lead said there were 35 prescribers and provided their signed declaration of competencies. Some of the PIPs listed on the website were not included in the information provided by the clinical lead, so might not be currently prescribing. The 'meet the team' section of the website included dermatologists and GMC registered doctors, so people might think they also prescribed for the service. The pharmacy promoted unlicensed POMs on the website and there were references to discounts. For example, the first month was £2.90 rather than £24.99, and people could claim £5 off the second month, which might encourage inappropriate use of medicines. This was discussed with the SI and the pharmacy lead and referred to the MHRA for consideration.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are well managed, so people receive appropriate care. The pharmacy obtains its medicines and raw materials from reputable sources. And it carries out checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

Details about the pharmacy's services were stated on the website. Information about the ingredients and links to studies were available on the website as well as information on skin conditions and people's treatment journeys. The pharmacy posted regular blogs. The most recent one 'Why is tretinoin so effective for anti-ageing' was written by a copywriter and reviewed by a GP who was a clinical content lead for the company. People communicated with the pharmacy via the customer service team and could ask to speak to a pharmacist or prescriber.

The online consultation was developed in such a way that the person was not guided through the consultation. Responses could not be edited once submitted to the clinical team for review. Once the person using the prescribing service completed their online consultation and uploaded photographs of themselves, the prescribers reviewed these with reference to previous consultations where applicable. A new consultation was triggered if there was any change to the person's condition. Every request for treatment required photographs to be uploaded. The prescribing system highlighted people's responses to the online consultation in a colour-coded format. This drew attention of the prescribers to answers which required consideration such as pregnancy status and helped flag clinically relevant information easily. The pharmacy had a process in place for prescribers to escalate clinical queries to one of the clinical team leads.

Prescribers treated a limited number of conditions, and each condition had its own formulary. The prescribing system was able to remove formulations of medicines unsafe in pregnancy if a person stated they were pregnant when completing the online questionnaire. Whilst people could select any condition, the prescribers assessed the information provided against all conditions and decided the diagnosis themselves. During the online consultation people could include any questions or comments they felt were important using free text boxes. People had the option to provide consent to share their treatment information with their GP. Letters were printed out and posted to the person's usual prescriber when consent was received, although confirmation of this did not appear to be recorded on the persons consultation records. Only a small percentage of people provided their GP details which could mean that most people's usual prescriber was not aware of treatments that they were receiving from the pharmacy. All orders had a set quantity of one 15mL bottle per month unless in exceptional cases, such as holiday. In these exceptional cases, the formulation team advised on stability issues of someone was going to use a supply for more than one month. The pharmacy treated facial acne. Anyone who wished to treat acne on other areas of the body was referred to their GP.

A sample of consultation records were reviewed during the inspection. Photographs, online questionnaire responses and previous clinical notes were visible on each person's consultation record. There was a visible audit trail of previous orders. And of who made comments and additions to the record, including details of who prescribed the medicine(s). In one consultation, a person had advised

that they were not using effective contraception but the medicine (a formulation containing tretinoin) was still prescribed. There was no record to show that this had been discussed with the person. The clinical team explained that emails were automatically sent to alert the importance of effective contraception. But there was a risk that the person may not see this email or understand the advice.

The pharmacy prepared a range of unlicensed POMs, some of these were different forms of the same formulations such as creams and lotions. Several different batches were made each day. Some treatments were based on licensed products with additional ingredients. The medicines were prepared in the compounding room and labelled at a labelling station on the ground floor. The compounding room was clean and well organised. The SI said that the pharmacy was following the principles of Good Manufacturing Practice (GMP), but the team did not make all the records required by the MHRA, as it wasn't necessary because they weren't regulated by them. Members of the team working in the laboratory wore full Personal Protective Equipment (PPE), including disposable gowns, hair nets, face masks, gloves, shoe covers and goggles.

Base ingredients were purchased from reputable suppliers. The pharmacy requested Certificates of Assurance (CoA), conformity and GMP records for every batch ordered. Raw materials were either sent to a third party to carry out checks or tested in house using the pharmacy's own equipment before a supplier was used. Stock sheets were used to log the amount of stock prepared and their expiry date. During development of new products preparations were tested to confirm that expiry dates generated by the pharmacy were appropriate.

When working in the compounding room, worksheets were prepared by a team member and double checked by a pharmacist or ACT. The required ingredients were collected and placed in tubs which were used to mix the ingredients. The tubs were pre-labelled with the formulation, batch number, strength, and batch size. The ingredients were weighed by the compounding staff and double checked by a pharmacist or ACT. Ingredients were added according to the formula and specific mixing programmes were used depending on the formulation. There were six mixing machines. Once ingredients were mixed, the preparation was checked and signed by a pharmacist or ACT. A member of the production team carried out pH and density checks. A pharmacist or ACT carried out quality and texture checks, including colour and odour. The pharmacy had equipment which it used for quality assurance. This was used when formulating new products. The texture and pH of a samples were checked for stability over time. An oven and a fridge were available for stability testing. There was no other routine checking of products once the formula had been determined stable. Routine assay checks to test concentration were not normally carried out. Duplicate medicine labels were attached to batch sheets so that people could be contacted if there was an issue with a particular batch. The pharmacy kept records of any issues in the compounding process. For example, information missing on batch sheets, or incorrect expiry date and these issues were formally reviewed 6-12 monthly.

The team member responsible for labelling the filled plastic bottles had access to the production record spreadsheet which detailed which preparation had been made, the amount, and the date it was made. There was a colour-coded system on the spreadsheet to help members of the team identify the stage of the process. The bottles were then labelled using a laser printer before being stored on designated shelves in the dispensary.

There were separate stations for processing and labelling prescriptions, packing, and assembling preparations, checking, and dispatch. The workload was high, and the dispensary benches were very full at times. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. Red baskets were used for people who were pregnant, so extra checks would be taken with their medicine. Baskets were stacked to make more bench space available.

During the dispensing process, a dispenser placed the filled plastic bottle in an outer box and checked the label and medicine against the worksheet. Another dispenser labelled the outer box with the medicine label and carried out a second check. A final accuracy check was then conducted by an ACT or pharmacist. A worksheet and medication labels were used to dispense and check against during the dispensing process. Prescriptions were not routinely printed out, but the prescription could be viewed and printed out if necessary. The pharmacy lead explained that the medication label was generated directly from the prescription, so there was no possibility of an error occurring when the medication label was produced. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. There was no clinical check by a pharmacist as part of the checking process. The pharmacy lead explained that it was not deemed necessarily as a clinical check had been carried out by the clinical team before the prescription was authorised and by the prescribing pharmacist.

A 'QR code' containing a link to a patient information page was printed on the outer box. This meant that people had access to up-to-date information about their treatment. Treatment guides were sent with some of the medicines. For example, any containing tretinoin. And people were advised that pregnancy needed to be reported to the pharmacy and treatment reviewed. People were able to update their own details on their login. And there were regular notifications sent to people to remind them to update their medical information. The boxes containing the medicine were packed in mail bags at the dispatch station. The medicines were sent using Royal Mail 48-hour service which could be tracked by the pharmacy and could be posted through people's letter boxes. People were notified once their treatment was dispatched. A returns log was maintained if an order was returned to the pharmacy. People were refunded if their orders were not delivered. Medicines which were returned were not re-used and were destroyed.

Alerts and recalls were received via email messages from the MHRA. These were read and acted on by a member of the pharmacy team. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. The team maintains and monitors the equipment it uses so that it is accurate and fit for purpose.

Inspector's evidence

A maintenance log was kept for all the equipment and machines used at the pharmacy. Balances used for measuring weight were tested regularly and calibrated annually by an external company. The pH meter was calibrated at least once a week. The filling and mixing machines were serviced annually and kept in good repair. There was a fume hood in the laboratory which was serviced yearly. Scoops, spoons, and spatulas were cleaned with soap and water, and alcohol. The pestle and mortars were soaked and washed using a suitable detergent. An ultrasonic cleaner was used for some items. Medicine bins were used to dispose of waste medicines. Members of the team had access to the internet and several up-to-date reference sources.

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.