

Registered pharmacy inspection report

Pharmacy Name: Millennium Pharmacy, 29-31 Shaw Street, St. Helens, Merseyside, WA10 1DG

Pharmacy reference: 9011768

Type of pharmacy: Community

Date of inspection: 14/11/2024

Pharmacy context

This is a community pharmacy situated in the town centre of St Helens, in Merseyside. The pharmacy dispenses NHS prescriptions and offers NHS services such as a minor ailment service and emergency hormonal contraception. The pharmacy also dispenses private prescriptions, some of which are for aesthetic treatments and products sold through its website. And it has an on-site private clinic service provided by a pharmacist independent prescriber to treat some minor conditions. The pharmacy supplies medicines in multi-compartment compliance packs for some people to help them take their medicines at the right time.

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 has written procedures to help the team work effectively and written risk assessments have been completed for all the private services it provides. Team members make records of dispensing mistakes and take steps to learn from them and to make the pharmacy's services safer. The pharmacy largely keeps most of the records that are needed by law. The pharmacy has processes available which team members follow to keep vulnerable people safe and protect confidential information.

Inspector's evidence

The pharmacy provided some of its private services through its website <https://www.millenniumaesthetics.co.uk/>. A range of non-surgical cosmetic treatments were supplied to aesthetic practitioners against electronic prescriptions written by UK prescribers. Practitioners could also purchase non-prescription items directly from the website, such as dermal fillers and injectable consumables. Aesthetic practitioners who wished to use the website were required to open an account which needed to be approved by a member of the pharmacy team.

For an account to be approved, an aesthetic practitioner had to provide a copy of their ID and evidence that they had completed a suitable course for the aesthetic product being requested and their insurance. Products which they could select from the website depended on their qualification. And prescribers had to provide details of their professional registration, and evidence that they were competent to prescribe aesthetic products. Some checks were completed on the registration of the prescriber when further prescriptions were supplied. The system created a digital stamp and recorded the name of the person who had checked each time this was done. A list of practitioners' qualifications as well as the date of expiration was also kept. This was checked to ensure the date had not elapsed when supplies were made. The pharmacy asked practitioners to provide proof of professional indemnity insurance. Practitioners were not able to place orders through the website until their account had been approved. If the account holder ordered a medicine that required a prescription, the generated an electronic prescription and then a prescriber linked to their account approved it. Or the person could authorise the prescription themselves if they had the authority to prescribe. The orders were then supplied by the pharmacy and sent via courier.

The pharmacy had written procedures for the aesthetics service to ensure team members fully understood their responsibilities and what was expected of them. A written risk assessment was available which showed how it had identified and managed the risks associated with the service and the treatments it supplied. The pharmacy team were able to give examples of steps that were taken to manage specific risks that were involved in providing the service at a distance. For example, there were quantity limits for the amount of botulinum toxin as well as weight loss injections that could be supplied. Aesthetic treatments and products were only delivered directly to the aesthetic practitioners, who were responsible for administering the product to the intended person. And the pharmacy had an account opening process.

Since the last inspection the superintendent pharmacist (SI) had created a guide for the aesthetics service for locum pharmacists. The guide explained how the service operated and also had screenshots to help locum pharmacists use the system functionality. Pharmacists needed to sign the guide once they had read and understood the information. Another change which had been implemented since the

last inspection included having information on each prescription of how many times the specific product had been prescribed for the person previously, the quantity and the interval between supplies. If there were any anomalies, team members checked and documented the information in the notes. There had been instances in the past where prescriptions had been cancelled either due to issues with the interval between supplies or the quantity prescribed.

The pharmacy also offered face-to-face consultations with a pharmacist independent prescriber (PIP). Treatments the PIP prescribed for included urinary tract infections (UTIs), fungal infection, weight loss, acne, and oral contraception. However, some NHS commissioned services had superseded a number of the conditions previously treated. At the time of the inspection the PIP was mainly prescribing for weight loss. People were seen face to face and the weight was checked on each consultation. There was a risk assessment for this service and clinical protocols which had been updated since the last inspection. The documents now included the information relating to the training and responsibility of the team members providing the services. The information had been reviewed by the prescriber. A template consultation form was included within the protocols which covered red flags, treatment plans and notification to the person's regular prescriber. However, the consultation form was not being used and the PIP was making notes on the person's electronic record. The SI explained that the pharmacy supplied a very low volume of medicines via this route, and this was evident from the dispensing records seen. The SI confirmed that people's regular prescriber was sent notification of treatment but evidence of this was not seen. There had been no formal audits or prescribing reviews undertaken since the start of the service to provide assurance that the prescribing was appropriate. The SI and IP had conversations in relation to the prescribing from time to time and provided an assurance that he would speak to the IP about arranging for a prescribing audit to be completed.

Standard operating procedures (SOPs) covering the services provided by the pharmacy team were available and had been read and signed by most team members with the exception of one staff member who had recently joined. The SI provided an assurance that they would read them by the end of the month.

The pharmacy had a process to record dispensing errors and their learning outcomes. Near miss incidents were usually recorded on a paper log. These were seen to be recorded. A staff summary audit was completed as part of which team members were provided with a record of their near misses. The team member then reviewed their own near misses to identify trends. The SI also reviewed near misses and errors overall to identify any trends and patterns. It had been identified that the same error had happened twice in a short period of time and a review had found that the locum dispenser had been unfamiliar with the pharmacy and its processes. The pharmacist discussed any learning points with team members at the point of identifying a mistake. Following a past review, tramadol was stored on a separate shelf which was labelled to draw attention when picking. Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) was investigated and recorded on an online system and on an internal form. The SI would investigate and have a huddle with the team to share learning. As a result of a past error team members had been briefed to ask a colleague to second check their work when they were combining medicines in original packs.

The responsible pharmacist (RP) had their notice on display. The pharmacy had a complaints procedure, and a current certificate of professional indemnity insurance was on display. Records for the RP and private prescriptions appeared to be in order, although some pharmacists were not signing out and some private prescription records seen did not have details of the prescriber recorded. Controlled drugs (CDs) registers were maintained with running balances recorded and checked regularly. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available, and the pharmacy team had completed training on it. Confidential information was separated to be removed by a waste carrier.

Safeguarding procedures were in place. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were in the safeguarding folder. The delivery driver had read the SOPs for safeguarding. Safeguarding in relation to aesthetics and weight loss was discussed with the team as part of discussions.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a superintendent pharmacist, a pharmacist independent prescriber (PIP), two accuracy checking technicians, seven trained dispensers, three trainee dispensers, a new team member who was due to be enrolled on the dispenser training course, a team member who packed orders, a medicines counter assistant and two delivery drivers. Locum pharmacists also provided pharmacist cover. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by team members and a staggered holiday system. Team members were trained to work across the different areas in the pharmacy, but certain tasks such as using the robot was assigned to certain team members. All team members had assigned roles.

Members of the pharmacy team completed some additional training via the eLearning for health (elfh) portal and also had access to another third-party learning platform. The SI reminded team members about training modules to complete when he received any updates from the Local Pharmaceutical Committee (LPC). Training records were kept showing what training had been completed. The PIP provided private consultations on behalf of the pharmacy, and where he felt it was appropriate, would issue prescriptions. He had completed some training for the conditions which the pharmacy offered treatments for. But this was generally limited to reading national guidelines and other literature, and from his experience working at a GP practice. But he did not have any written records for the training he had completed.

Since the last inspection the pharmacy had introduced additional training which was provided to locum pharmacists in relation to aesthetic products which were supplied from the pharmacy.

Team members gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. A dispenser said she felt a good level of support from the pharmacist and worked well with team members. Team members had annual appraisals with the SI. Members of the team were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no targets set by the pharmacy for professional services.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean and tidy and suitable for the services provided. A consultation room is available so people using the pharmacy can have a private conversation with its team members.

Inspector's evidence

The pharmacy is located within a business unit which had been specifically refurbished for use as a pharmacy. It was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. People were not able to view any patient sensitive information. The temperature was controlled using air conditioning. Lighting was sufficient. There was a separate entrance with a screened counter for people who attended the pharmacy for substance misuse and needle exchange services. Two consultation rooms were available, one of which was usually used as an office space and was vacated if needed for services. The entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

The pharmacy had two websites, one for both NHS and private clinic services, and another for aesthetic treatments and products. Medicines were supplied directly to healthcare professionals via the aesthetics website. The website contained details of the pharmacy and superintendent pharmacist.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally provides its services safely. The pharmacy gets its medicines from licensed suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

Access to the pharmacy was level and suitable for wheelchair users. There was also wheelchair access to the consultation room. Digital screens gave information about the services offered and information was also available on the pharmacy website.

The pharmacy had a delivery service for local patients receiving NHS prescriptions. An electronic device was used to keep a delivery record. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating that the pharmacy had attempted a delivery. Signatures were obtained from the recipient when CDs were delivered, to confirm receipt.

The pharmacy team initialled 'dispensed-by' and '-checked-by' boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual people's prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. The pharmacist performed a clinical check of all prescriptions, a stamp was used to create an audit trail and to indicate this had been completed. An accuracy checker was then able to perform the final accuracy check. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

The pharmacy used barcode technology to help manage some of its dispensary services, so that when a prescription was processed on the computer, and an audit trail showed it had been clinically and accuracy checked by a pharmacist. The required medicines were automatically ordered from the wholesaler and arrived in the same box. A member of the team then scanned the barcodes of the medicines, to print dispensing labels. The computer then instructed the team member to place the medicines into numbered baskets, which also had barcodes that were scanned to make sure the correct medicines had been placed into the correct basket. Each basket contained all the medicines for a specific person. Once the dispensing process had been completed for an appropriate amount of people, the medicines were placed into medicine bags for each individual person. An SOP was in place, and team members were suitably trained in the process.

The pharmacist was aware of the risks associated with the use of valproate during pregnancy. Educational material was provided when the medicines were supplied to people. The pharmacist had spoken to those who were at risk to make sure they were aware of the pregnancy prevention programme. And this was recorded on their patient medication record (PMR). Team members were aware of the using original packs when dispensing sodium valproate-based products. One person received sodium valproate in their compliance pack, a written risk assessment had not been completed for them which was not in line with the most recent guidelines. Following the inspection, the SI confirmed the risk assessment had been completed.

Some medicines were dispensed in multi-compartment compliance packs using an automated system. Before a person was started on a compliance pack, the pharmacy referred them to their GP to complete

a suitability assessment. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. The compliance packs were labelled with medication descriptions, batch numbers and expiry dates. All compliance packs were accuracy checked after dispensing. Patient information leaflets (PILs) were routinely supplied. From time to time the robot mis-dispensed compliance packs, and this was identified during the accuracy check. The compliance packs were corrected, and the erroneous tablets removed. A record was made of these errors and the team members were made aware. All packs were checked by the pharmacist or accuracy checker.

Electronic prescriptions were issued via the pharmacy's website for aesthetic treatments. These were authorised by UK prescribers. Prescriptions were signed by prescribers using a two-factor authorisation system where the prescriber was sent a PIN to their personal telephone or email. Once a prescription had been signed it could not be amended or changed by anyone including the prescriber. The pharmacy had a quantity restriction for all medicines that had been risk assessed as needing one including medicines containing botulinum toxins, so that no more than three packs were permitted in any one order.

Most dispensed aesthetic products seen had patient specific directions on the label. Where the directions were not included by the prescriber, team members emailed the prescriber to confirm the directions for use although this was not always done. The SI explained the checking process and provided an assurance that he would speak to the IT developers to ensure all prescriptions contained directions for use which would help them complete a thorough clinical check.

The pharmacy's computer system displayed information relating to individual orders and showed information about past orders which was visible on all prescriptions. Prescribers had to indicate that they had carried out a face-to-face consultation. Once the information had been processed on the computer, medicines were sent for delivery via courier or could be collected from the pharmacy counter. Medicines which needed to be kept refrigerated and were sent by courier were packaged in polystyrene boxes with ice blocks. The pharmacy had sent out a test package with a temperature data logger to ensure medicines were stored at the required temperature during the delivery process.

People could visit the pharmacy for a face-to-face consultation with the PIP for treatments for a variety of conditions. The PIP used the pharmacy's PMR software to record consultation notes. A review of records indicated consultations were conducted in line with accepted consultation models. A review of the private prescription register showed that very little prescribing was being carried out by the PIP and did not indicate medicines were being overprescribed.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked each month. Short-dated stock was highlighted and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet. There were clean medicines fridges, data loggers, emails alerts and checked as part of monthly SI check. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA printed and actioned.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Separate labelled measures were available and used for liquid CDs to avoid cross contamination. Equipment was clean and ready for use. A number of medical fridges were available. An automated device was used to measure liquid CDs when providing the substance misuse service. It was calibrated and cleaned daily. The robot used to dispense multi-compartment compliance packs had a service contract and was serviced annually. Members of the team routinely cleaned and maintained the robot. A log was kept when cleaning and maintenance had been carried out. Equipment such as blood pressure monitor, ambulatory blood pressure monitor, otoscope and digital thermometers were available and used as part of the services provided. Calibration arrangements were in place.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy. Up-to- date reference sources were available.

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.