General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy Online, Unit 6, Horizon 29, Buttermilk Lane, Bolsover, Chesterfield, Derbyshire, S44 6AE

Pharmacy reference: 9012214

Type of pharmacy: Internet / distance selling

Date of inspection: 07/08/2024

Pharmacy context

This pharmacy is located in a closed unit, and it is not accessible to members of the public. It operates as a central assembly hub dispensing medicines in original packs and multi-compartment compliance aid packs for a large number of the company's other pharmacies. In addition, the pharmacy operates as an online pharmacy dispensing NHS prescriptions for delivery to people's homes. The online pharmacy also sells a range over the counter (OTC) medicines, and it has a pharmacist-led private prescribing service. People access the online services through two websites www.peakpharmacy.co.uk and www.travelpharm.com. The unit contains the company's head office and its wholesaling warehouse.

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 generally manages risks to make sure its services are safe, and it accurately completes all the records that it needs to by law. Pharmacy team members work to professional standards, and they are clear about their roles and responsibilities. They record their mistakes so that they can learn from them, and they act to help stop the same sort of mistakes from happening again. Team members keep people's private information safe and understand how they can help to protect the welfare of vulnerable people. The pharmacy manages its online service reasonably safely. But the pharmacy could improve its prescribing policies, risk assessments and audits, to demonstrate and make sure that its online systems and processes are safe and effective.

Inspector's evidence

The pharmacy had started operating ten months ago and became fully operational four months ago. It had standard operating procedures (SOPs) for the services provided, which were available in electronic format. There were records to show that members of the pharmacy teams had read and accepted them. SOPs which related specifically to the compliance aid pack service were kept in the area where the packs were assembled, so team members could refer to them The pharmacist superintendent (SI) was reviewing some of the SOPs to ensure they covered everything required. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. Team members wore uniforms and name badges which identified their roles. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

The hub dispensed a high volume of original packs and compliance aid packs for the company's 'spoke' pharmacies. Compliance aid packs were assembled by an automated dispensing robot which had 24-hour technical support via a helpline. The team were supported via webcam if there were software issues, and it could move to manual assembly of packs if the robot could not be fixed quickly.

The hub's original pack dispensing service used advanced automation which consisted of two 'line' machines. A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services. In the event of a major systems failure in the original pack dispensing service, the software company would be contacted and would work to resolve the issue. This had happened on just one occasion and the issue had been resolved within an hour. If the issue could not be resolved within a short period of time, the team could ask spoke pharmacies to stop sending data to the hub and dispense prescriptions in branch until further notice. Spoke pharmacies had capacity to deal with this and were able to use locum staff or relief staff if extra support was needed.

There were SOPs for dealing with incidents, errors or near misses. Near miss incidents were recorded on special logs which had been tailored to the types of issues encountered in the different areas of the pharmacy. For example, in the hub's compliance aid pack area, issues involving broken, missing, or extra tablets or capsules were reported. The pressure of suction had been adjusted on the robot to reduce the risk of these types of errors. All checking benches in this area had a near miss record sheet. As a result of near misses, controlled drugs (CDs) which were not subject to safe custody regulations were now stored on different shelves and required two people to check them. Separate near miss recording sheets were kept near the accuracy checking station in the original pack dispensing area.

Near misses were uncommon and usually due to some items missing from the sealed bag. Changes to processes were discussed at meetings and then shared on an electronic messenger system for the benefit of the team members that weren't present. Reviews of near misses were carried out, but were not routinely recorded, so the team might be missing out on additional learning opportunities. The SI agreed to look into doing this going forward.

Dispensing incidents identified by spoke pharmacies were reported to the SI office who informed the relevant team at the hub. An investigation of dispensing error where a person had been supplied with the incorrect formulation of Tegretol in a compliance aid pack had identified that the error occurred at the validation of the product stage. The packs of patients who were supplied with the same medicines were called back, checked, and their packs reassembled. Information was shared with the robot's software provider, and they completed their own investigation. This had happened when the process was fairly new, and errors of this type were very uncommon. A more recent incident where lamotrigine tablets were missing from a pack was being investigated. Following the inspection, the SI confirmed that some issues with the accuracy of some of the packs had been identified. Mistakes were usually due to 'jumpers' when a tablet or capsule moved into the wrong compartment, or missing doses, which had not been noticed at the manual accuracy checking stage. The SI provided assurance that these issues were being dealt with and explained that the hub would not be supplying any additional spoke pharmacies until the issues had been resolved. Actions taken included the introduction of additional visual checks of the packs, and ensuring the pharmacists and accuracy checkers were given sufficient breaks from checking duties to avoid fatigue.

Dispensing errors that had occurred in the original pack dispensing area were usually due to human error. A recent error which had occurred had included someone else's item being placed in another person's bag. This had been missed at the manual check. Following the incident, the checking team had all been briefed to ensure a thorough check was always completed. Clear plastic bags were used for assembled CDs and insulin in the online pharmacy to allow an additional check before delivery. All dispensing incidents were discussed within the pharmacy teams and actions taken to prevent re-occurrences were recorded. They were reported to the SI's team and discussed at senior leadership team meetings. The SI team reported them on the National Reporting and Learning System and shared learnings with other pharmacies in the group, in a weekly email.

As well as dispensing and delivering NHS prescriptions to people in the local area, the online pharmacy supplied prescription only medicines (POMs) and OTC medicines through the pharmacy's websites. People were required to set up an account when they started using the pharmacy's online services. People's identity (ID) was verified for all POMs and age restricted OTC medicines, including pharmacy (P) medicine. The pharmacy used a third-party ID checking service, which was integrated into the websites. If the person failed the initial ID check, then they were asked to upload a photograph of their passport or driving license. ID checks and postcode audits helped to ensure people didn't make duplicate accounts to obtain extra medicines.

POMs were offered via the websites for malaria prevention, hay fever and allergies, erectile dysfunction (ED), altitude sickness, emergency hormone contraception (EHC) period delay, traveller's diarrhoea, hair loss and jet lag. These conditions had been chosen as they did not require monitoring and didn't involve high-risk POMs. The most commonly prescribed medicines during the previous week were for malaria prevention.

Risks had been identified around inappropriate sales and quantities of P medicines, and some maximum limits had been set to prevent people over ordering. Higher risk P medicines such as pain killers containing opioids, cyclizine tablets, Phenergan tablets and liquid, which were known to be overused and misused, were not supplied via the pharmacy's websites. Some diphenhydramine containing

sedatives were offered and accounted for around 60% of the P medicines supplied. A sedating antihistamine policy was available on the websites which signposted people to their GP if they required to take them regularly. There was a statement on the website that the pharmacy monitored all purchases of sedating antihistamines and used a variety of means to check and restrict purchases.

The pharmacy had risk assessments for its prescribing services. These identified the risks and the mitigating actions which would reduce or alleviate the risks. But the risk assessments did not identify the likelihood of the identified risk, and the potential impact before mitigating actions were put in place. And the risk assessments did not identify who was responsible for reviewing the risks and the timeline of when the risks would be next reviewed.

The pharmacy had prescribing policies for the services it delivered. The prescribing policies did not confirm how clinical information was verified. For example, if and how National Care Records (NCRs) would be accessed, or any other means of verification. The policies did not include details on how it confirmed a person's ID and whether it was optional or mandatory to inform the person's usual prescriber. Information on who had reviewed the policy, when it had been reviewed and when the next review was to take place were also missing. The pharmacist independent prescriber (PIP) who was working in the online pharmacy was covering for the regular PIP who was on annual leave. Following the inspection, the regular PIP confirmed that since the inspection, he had updated the risk assessments and prescribing policies to include the missing information.

The PIP explained that as well as prescribing for the online prescribing service, he occasionally worked as the RP. So, potentially he could carry out the final clinical and accuracy check on prescriptions which he had prescribed. He explained that he generally prescribed in the mornings, and it was usually in the afternoons when he sometimes carried out clinical and accuracy checks, so there was a separation of the functions.

The pharmacy did not provide any audits demonstrating how compliant it was with its own risk assessments and prescribing policies. And there had been no audits of high-risk P medication sales. Following the inspection, the regular PIP confirmed that since the inspection, he had worked out a plan of audits to use going forward.

There was a SOP for dealing with complaints and the complaints procedure and the details of who to contact about a complaint were available on the websites. Complaints and feedback from patients about the hub were received either via the spoke pharmacies or they could come directly to the hub pharmacy, as it's address, and phone number were on the medication labels. Any complaints or dispensing incidents would result in a team meeting being held to discuss next steps. The SI team would liaise with the patient or carer and then look into the incident and take the appropriate action. The spoke pharmacies provided feedback about the service they received from the hub via a portal which the SI monitored. The senior leadership team held monthly meetings and the pharmacy teams held ad hoc meetings if some learning was identified.

A current certificate of professional indemnity insurance was on display. The SI confirmed that it covered all the activities carried out at the pharmacy and explained that the insurance providers visited the pharmacy to ensure they understood everything that was taking place there. The PIPs had individual professional indemnity insurance to cover their own prescribing.

Private prescription records were maintained electronically. There was a separate register for the online prescribing service. The RP log was recorded electronically as part of the patient medication record (PMR) system. The CD registers were electronic and appeared to be in order. Records of CD running balances were kept and audited. Two CD balances were checked and found to be correct. Patient

returned CDs were recorded and disposed of appropriately. The online pharmacy kept a record of the responses from the online consultations along with 'thread messages' which were used when a PIP had contacted the patient for additional information or carried out any counselling and interventions. Details of phone calls and emails were attached to people's records. Each PIP had their own log in details and passwords. Electronic signatures were used on prescriptions and the IP address of the prescriber could be checked.

All pharmacy team members received information about confidentiality and safeguarding as part of a 'starter pack' when they commenced work at the pharmacy, and they were required to read and follow this as part of their contract of employment. There were SOPs on confidentiality and data handling, and team members had completed training on information governance and data security. Annual refresher training was completed. Confidential waste was stored in designated bags which were available in various parts of the pharmacy. They were collected by a third-party company for disposal. A dispenser correctly described the difference between confidential and general waste. There was a privacy policy and a cookies policy on the websites.

There was a 'safeguarding children and vulnerable adults' SOP. The pharmacists and pharmacy technicians (PTs) had completed level two training on safeguarding as a minimum. Some had completed level three. Other members of the team had completed training on safeguarding at levels relevant to their roles. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members receive training for the jobs they do. They work well together and communicate effectively. The pharmacy provides structured training and development, and it supports its team members to keep their skills and knowledge up to date. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

The staffing levels appeared adequate for the volume of work during the inspection and team members were observed working collaboratively with each other. Planned absences were organised on a calendar and there were detailed weekly staff rotas to ensure the workload was managed. There were two main teams in the pharmacy: one for the online pharmacy service and original pack dispensing hub, and the other for the compliance aid pack section. Rotas were used to ensure team members were trained and competent to complete the different tasks across both teams. The pharmacy also employed seven regular delivery drivers and a relief driver, three customer service assistants, and an IT and marketing assistant. Absences were usually covered by rearranging the staff rotas. In an emergency, there was the option to transfer staff from the other pharmacy team or from a neighbouring branch. Staff at head office, including the SI's team could be called to assist if necessary.

Members of the pharmacy team carrying out the services had completed appropriate training and had access to online training resources. Training records were available for each member of the team, and they had completed a variety of modules. The SI's team were able to access the training records to see if there were any outstanding training requirements. All the trainee dispensers were on accredited dispensing assistant courses and were given protected training time to complete their training. New members of staff completed induction training and received a review after three months. Team members all had KPIs and were given formal appraisals where performance and development were discussed. Reviews were held on a regular basis and the supervisors provided ongoing feedback.

The pharmacy team received a weekly email from head office which covered a range of topics including the company's performance, patient safety matters, and amendments to SOPs. Team members were required to read and sign it. The supervisors held regularly meetings, and relevant information was cascaded to their teams. The teams used an electronic messenger service to communicate when face-to face meetings weren't possible, and to ensure everybody was included. Team members described an open and honest culture in the organisation and confirmed that they felt comfortable admitting errors and would talk to their line manager about any concerns they might have. There was a listening forum and senior team members regularly visited different locations to speak to the teams. There was a whistleblowing policy. The SI was present at the inspection. The project support leader, who was an ACT, was also present. A central assembly manager provided additional support to the teams, but she was absent. The RP was a regular pharmacist, and he worked most days at the pharmacy.

The team working in the online pharmacy and the original pack dispensing hub were split into two sub teams and worked in two separate shifts. Sub-teams consisted of a qualified dispenser and three or four trainee dispensers. A different RP usually covered each shift. There were four supervisors who were accuracy checking technicians (ACTs) or accuracy checking dispensers (ACDs). A chart showed which of the trainee dispensers were competent to carry out each activity in the pharmacy. They were signed off as competent when they had completed at least one week of performing the activity,

without any issues.

The PIP confirmed he was competent to prescribe in all the areas which the website offered and had prescribing experience in a GP practice. He had carried out training on malaria prevention and minor ailments, and had particular expertise in the respiratory system, which included sinusitis and hayfever. The PIP had read all the prescribing protocols and had shadowed the regular PIP for two weeks before he prescribed alone. He said he could always contact the regular PIP if necessary to discuss any issues. The PIP felt empowered to exercise his professional judgement and confirmed that he could comply with his own professional and legal obligations. For example, refusing to prescribe a medicine or supply a P medicine containing a sedative because he felt it was inappropriate. The team were not under any pressure to achieve targets.

In the compliance aid pack section, there were three pharmacists, an ACT, five ACDs, two qualified dispensers, thirteen trainee dispensers and an administrator on the team. Bank staff were also used when necessary. The pharmacy was recruiting two new shift supervisors. There was a regular pharmacist who worked most days and some regular locum pharmacists on the team. Team members completed role specific training which included how to use the robot. Once they were competent and were signed off, they were then able to move into the role and carry out tasks independently.

Team meetings were held weekly and sometimes members of the head office team joined them. The supervisor joined in any company wide meetings and cascaded relevant information to the team. There were targets in place which were based on the number of trays to be assembled, but the team understood this must not compromise patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the provision of healthcare services. Its websites provide useful information about the pharmacy and its services. But website information is occasionally inaccurate or misleading, so people might not have the correct information to make an informed decision about their care.

Inspector's evidence

The pharmacy premises was situated in an extensive purpose-built unit on a business park. The unit also housed the company's large warehouse and its head office. The pharmacy was clean, secure and in a good state of repair. There were designated work areas which were well organised, neat, and tidy. Cleaning was carried out by the pharmacy team and cleaning rotas were in place. There had been a recent leak, so some of the carpet had been removed. A team members confirmed that this had been dealt with promptly, and they were just waiting for the carpets to be replaced. Temperature and lighting were adequately controlled. Team members had access to WCs with wash hand basins and hand wash, a staff tea room with a kitchen area, offices, a wellbeing room, a gym, and showers. There was a dispensary sink for medicines preparation with hot and cold running water. Members of the public did not enter the pharmacy and it did not have a consultation room.

The pharmacy's websites contained some information about the pharmacy and its services. The pharmacy's address and the prescriber's details were displayed on the websites. But there was some misleading information on the websites. For example, the pharmacy's GPhC registration number was incorrect in some places. This was rectified shortly after the inspection. The websites displayed the RP and the PIP on duty. However, there were recent instances when the incorrect name was displayed. The SI said she would remind team members of the importance of updating the website regularly to ensure the correct details were displayed. Some healthcare information was inaccurate as underneath the 'Get Started' button for Nytol on the website, it stated, 'read our stimulant laxative policy' and linked to the policy. This was confusing as Nytol is used as a sedative and not a laxative. The PIP said he would look into getting this corrected.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy sources, stores, and supplies medicines safely. It carries out some checks to ensure medicines are in good condition and suitable to supply. But it could improve its management of alerts and recalls, to ensure its actions these promptly. The pharmacy's hub operations are well organised. But people receiving compliance packs might not always have easy access to information leaflets that they may need to take their medicines safely. The pharmacy's online prescribing services are well managed, but the prescribers are not routinely sharing information with people's usual doctor. This means that they may not have relevant and up-to-date information about the person to support ongoing safe and effective care.

Inspector's evidence

Details about the pharmacy's services were stated on the websites. Services available in other branches of the company were shown on the websites. This helped to inform people of services and support available elsewhere. People using the pharmacy could communicate with the pharmacist and staff via the telephone or by email.

The pharmacy operated three separate dispensing areas; the online pharmacy, the multicompartment compliance pack dispensing hub, and the original pack dispensing hub.

The online pharmacy.
People could nominate the pharmacy to dispense their NHS prescriptions which were sent to the pharmacy by the Electronic Prescriptions Service (EPS). Prescriptions were delivered to people's homes by the pharmacy's delivery drivers. Each delivery was recorded, and the delivery drivers used Apps on their mobile phones to confirm the safe receipt. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

A large number of the NHS prescriptions were dispensed by the pharmacy's original pack dispensing hub, following the same process that the spoke pharmacies. And a pharmacist was required to carry out a clinical check on any prescription before they were passed to the hub for assembly. The details of which pharmacist had carried out the clinical check was recorded electronically. The online pharmacy dispensed all split packs, CDs, and fridge lines as these weren't dispensed by the hub.

Space was adequate in the online dispensary and the workflow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. ACDs ad ACTs carried out accuracy checks of prescriptions when a pharmacist had initialled the prescription to confirm it had been clinically checked. Baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. The RP was aware of the requirements for a Pregnancy Prevention Programme to be in place for people who were prescribed valproate, and that original packaging should always be used. He confirmed that people would be telephoned to provide counselling if necessary. He wasn't aware about the new requirements for topiramate but confirmed he would look into this. One of the supervisors said he would obtain some of the topiramate care cards, so these could be supplied when necessary.

CDs were stored in four CD cabinets which were securely fixed to the wall. The keys were under the

control of the RP during the day. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Medicines were stored in their original containers at an appropriate temperature. Date checking of the dispensary shelves was carried out and documented. Short-dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins. There was a procedure for head office to send emails to pharmacies in the company with the details of alerts and recalls. A team member was supposed to act on them and keep a record of their action, and in some circumstances the team were required to send a confirmation e-mail to head office. Two of the supervisors, who were present, couldn't recall receiving any emails since moving to the new premises. They said that they would check with the SI team to ensure they were receiving them, but they knew where to find information to check if a medicine was subject to a recall.

People could visit the pharmacy's websites and request a POM by filling in an online questionnaire which was assessed by one of the PIPs before the pharmacy supplied the medicine. The PIP reviewed the answers to the questionnaire, checked the person's previous order history and contacted them by 'thread message', telephone or email if they required any additional information. For example, there were messages between the PIP and a person requesting Malarone for malaria prevention. This was because they were currently prescribed leflunomide which raised concerns about their liver function. The PIP demonstrated instances when he refused supplies as he didn't feel they were appropriate. For example, a person who requested the emergency hormonal contraceptive Ella one for the second time in a week. They were refunded and signposted to their GP. During the online consultation, consent to share information with the person's GP was requested. But the pharmacy did not inform the person's usual prescriber when they supplied a medicine unless there was a significant issue. This meant that their GP may not have relevant and up-to-date information about the person to support ongoing safe and effective care. And this was misleading as the person receiving the medication could be under the impression that their GP had been made aware of the supply. Consent to access National Care Records (NCRs) was requested during each online consultation. The PIP was able to access people's NCRs and he confirmed that he sometimes accessed them when he needed to confirm information entered on the online consultation. For example, if he didn't have assurance of a person's blood pressure or wanted to check recent liver function results.

People wishing to purchase P medicines online were required to answer some questions. There were also free-type boxes for some of the medicines. The PIP reviewed the answers and checked the person's previous purchase history before approving the supply. There was an example seen of a person who had received the sedative diphenhydramine two months running and was requesting it for a third time. The PIP said he would probably refuse the request and signpost the person to their GP. Private prescriptions and P medicines from the online pharmacy were posted to patients by a 24-hour Royal Mail service which could be tracked by the pharmacy.

Assembly of multi-compartment compliance aid packs at the hub.
There was plenty of space and the workflow was organised into separate areas, with a designated checking area and a separate de-blistering room. The dispensary shelves were well organised, neat, and tidy. Compliance aid packs were assembled by the robot following receipt of the details of the prescription from the spoke pharmacies. There were secure systems with specific networks and firewalls to transmit the data. The turnaround was usually completed in a week, and each pharmacy has a specific day when data was entered. Data was sent two weeks in advance of when patients were due their packs. Once data was received at the hub, it was copy and pasted onto the system. It printed a list of patients for each branch and then filed into what day it was due to go back. Number codes were entered onto the robot which had all the information it needed. The preference was to have the prescription in advance although the SOP allowed for data to be transmitted even if the prescription

had not been received. Packs were only supplied once the prescription was received.

The clinical check was carried out at the spoke pharmacies and any patient counselling was carried out there. The compliance aid packs' labelling sheets were printed out by the PMR system which was linked to the spoke pharmacy's system via a secure connection. Medicine descriptions were included on the labelling sheet and photographs of the medicine were included for most of the medicines, to enable identification of the individual medicines. Packaging leaflets were not usually included. Instead, a link to the medicines.org website was on the front of the compliance aid packs which people could use to find information about their medicines. One of the team members said the spoke pharmacies would print out packaging leaflets for people who requested them, or the hub pharmacy could print them and supply them with the assembled packs. This facility had been highlighted to people in a letter which was sent out to people before their medicines started to be assembled at the hub.

All medicines were de-blistered into tubs prior to filling cassettes for the robot to assemble from. This activity was carried out by a specific team in a separate room which contained four manual and one electronic machine. All workstations had a poster with the de-blistering method recorded. All the tubs contained medicines from the same batch. Each tub contained two original packets from the batch. This was used for reference and its bar code was scanned to confirm that it contained the correct medicine during the filling and assembly process. De-blistered medicines were checked by a pharmacist or ACT. The tub was labelled with the details of the medicine including its expiry date. Date checking was carried out every 4 weeks. Any tubs which contained medicines with an expiry date within the year were highlighted using red stickers. A member of the team said the turnover of stock was very high, so they were all likely to be used within 3 months. They explained that they checked the packaging leaflet to ensure that it was safe to remove the medicine from its original packaging before de-blistering it. The role of replenishing the robot's cassettes was accuracy checked by a pharmacist or accuracy checker and a log was maintained of this process, with the details of who had replenished and who had accuracy checked it. Two designated team members generally loaded medicines onto the robot. Medicines were sometimes added manually to the compliance aid packs because they couldn't be used by the robot. For example, Adcal tablets because they were too large, or if half a tablet was required rather than full tablets. Most trays were assembled by the robot and under 10% of trays were prepared manually.

A pharmacist or accuracy checker checked the completed compliance aid packs following assembly. This check was for accuracy of the contents of the pack against the labelling sheet, and also to check the integrity of the tablets and capsules. Any damaged tablets and capsules were removed and replaced, and missing, extra or 'jumpers' were corrected. Dispensed by and checked by boxes were initialled on the packs to provide an audit trail. Once checked, packs were placed in clear plastic bags which had patient details on and placed in totes. Each spoke pharmacy had their own totes, which were labelled with the number of totes. Totes were strapped and sent to the transport team for delivery. There was an electronic audit trial of this. The pharmacist at the spoke pharmacies checked the labelling sheet against the prescriptions before the packs were supplied. Communication sheets were used to send messages between the hub and the spoke pharmacies about any changes in brands or any missing items which needed to be added at the spoke. This process was to be made more robust following some errors when additional medicines had not been added by the spoke pharmacy.

Recognised licensed wholesalers were used to obtain medicines. Liquid medicines were not stocked by the pharmacy as only solid doses could be used by the robot. Schedule 2 CDs and medicines requiring cold storage were not stocked. Sodium valproate was not dispensed from here, and team members were aware of the recent change to requirements. Alerts and recalls were received via email messages from the superintendent's office. These were read and acted on by a member of the pharmacy team and filed electronically.

Original pack dispensing at the hub.
Data from the prescriptions was entered onto the system by spoke pharmacies. This was accuracy checked at the spoke before being transmitted to the hub. Secure systems were used to transmit data. Prescription data sent before 1pm were prepared and sent out by the hub the following day. As part of the onboarding process spoke pharmacies were required to manually check the first 500 orders that were sent, and all dispensers were required to complete and be signed off on labelling competency. Each area had a coach who spent time with spoke teams when they first started using the system and would be the first point of contact if there were any issues. Consent to have medicines dispensed at the hub was gained from patients in branch, and there was an option for people to opt out. Those who agreed to use the service were sent a specimen bag to show how they would receive their medicines. Antibiotics, any acute medicines, CDs, split packs, glass bottles, bulky items or those in very small packs were not dispensed from the hub. Medicines which required ongoing monitoring and high-risk medicines were dispensed but all monitoring was done by the spoke pharmacies. Prescriptions were clinically checked in the spoke pharmacies and the name of the person carrying out the clinical check was recorded electronically.

Stock for this was obtained directly from the company's on-site warehouse and checked by a pharmacist before being loaded onto the A-frame from where it was sent for processing. The system also accuracy checked items using barcode scanning technology. If a barcode was not recognised the dispensed medicines could be ejected for a manual check. Expiry dates were also checked on packs which had a 2D barcode. The automated process included sensors to identify any irregularities with the dispensed medicines. If the sensors detected any possible irregularities the medicines were diverted to a manual accuracy checking station. A report of all the irregularities was produced the following day and reviewed. There was no process to carry out spot checks on dispensed medicines other than those flagged and sent for a manual check. The operatives in the hub were either qualified or trainee dispensers. Manual checks were done by either pharmacist, ACDs or ACTs. If any changes were made by the checkers the label was initialled. The pharmacy held a log of who was working on the checking bench at any given time. Medicines were packed in heat sealed bags by the robot. Manual accuracy checking benches also had a heat sealer to reseal bags once the check had been completed. The unit did not hold stock other than that which was being processed. Date checking was carried out by the warehouse. Dispensed medicines were packed into totes which were sealed using straps and sent to the transport team who delivered them to the spoke pharmacies.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy teams have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy teams could access the internet for the most up-to-date information. For example, the electronic British National Formulary (BNF) and BNF for children. There were four clean medical fridges for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. PMRs were password protected. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs.

There was an IT team onsite. The robots were regularly serviced, and maintenance contracts were in place. The team could contact a helpline if problems occurred with the compliance aid pack robot. De-blistering machines, which were used in the compliance aid pack area, were cleaned down after each use. Engineers were present on site throughout the shifts to deal with any issues with the original pack dispensing system. Checks were carried out each morning which included running a test patient through the system.

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.