General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 55-57 Main Street, ABERCHIRDER, Aberdeenshire, AB54 7ST

Pharmacy reference: 1041589

Type of pharmacy: Community

Date of inspection: 21/07/2023

Pharmacy context

This is a community pharmacy in Aberchrider. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs). The pharmacy also provides Post Office counter services.

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

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and review the pharmacy's processes and procedures. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. The SOPs were available on the company's online operating system. And team members had printed hard copy versions to keep in the dispensary for ease of access. A designated folder was used for SOPs and this included evidence to show team members had read and signed them. A range of 'Standard Dispensing SOPs' were available, but they showed they had passed their September 2021 review date. This included the 'Accuracy Checking Technician (ACT) Final Check and Bagging SOP' and the 'Selection and Assembly SOP'. Dates on the digital copies showed they had been reviewed and updated. And the pharmacy technician undertook to replace the printed versions. The pharmacy technician was undergoing training that would allow them to carry out final accuracy checks. And the pharmacy had ordered a stamp for pharmacists to use to annotate the prescriptions they clinically checked and approved for checking.

Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the ACT were able to help individuals learn from their dispensing mistakes. The dispensers recorded their own near miss errors, and the RP generated a report which showed the top 5 errors and any associated patterns and trends. The report for June 2023 was displayed on the dispensary wall and it also provided information about dispensing mistakes that people reported after they left the pharmacy and drug recalls for the month. The content of the report was discussed at a regular monthly meetings to help team members identify dispensing risks and help them make safety improvements. The superintendent's (SI's) office reviewed the reports from all its branches to identify patterns and trends across the company. And the SI produced a quarterly team briefing that they issued to highlight any significant dispensing risks and improvements for the team members to reflect on and implement if appropriate.

Team members provided evidence of improvements, for example they had separated 'look alike and sound alike' (LASA) medication such as pregabalin and gabapentin. The pharmacy trained its team members to handle complaints, and a SOP was available for them to refer to. A notice at the medicines counter provided information about the complaints process and provided contact information for people if they needed it. Team members knew to report dispensing mistakes that people reported after they left the pharmacy. And the pharmacist produced a report using an electronic template which they sent to the SI's office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 30 April 2024. The pharmacist displayed an RP notice which was visible from the waiting area. The RP record showed the name and registration details of the pharmacist in charge. But it did not

always show the time their duties ended.

Team members maintained the controlled drug (CD) registers and kept them up to date. And they evidenced that they mostly carried out balance checks once a week. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of 'specials' that were up to date. A notice at the medicines counter provided information about the pharmacy's data protection arrangements. And team members knew to keep confidential information safe. They used designated containers to dispose of confidential waste. And it was collected by a team member from the company's head office for off-site destruction. Team members knew to manage safeguarding concerns and the pharmacy provided a policy for them to refer to. A notice on the consultation room door informed people that the pharmacy participated in the UK 'Safe Space' initiative so they could ask for help. And team members knew to speak to the pharmacist whenever they had cause for concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's dispensing workload had remained mostly the same over the past year. And the company had not needed to make any changes to staffing levels as a result. A regular 'responsible pharmacist' (RP) worked at the pharmacy and the company arranged locum and relief pharmacist cover when needed. A dispenser was on annual leave at the time of the inspection and a relief dispenser had been providing cover at busy periods throughout the week. The following team members worked at the pharmacy; one full-time pharmacist, one full-time pharmacy technician, two full-time dispensers, one part-time pharmacy student who worked Saturdays. At the time of the inspection, the pharmacy was hosting a pharmacy student as part of the 'Overseas Pharmacists' Assessment Programme' (OSPAP). They were supported by the team members and had been gaining experience in dispensing procedures.

The pharmacy supported team members to learn and develop and it provided protected learning time in the workplace. The pharmacy technician had almost completed an 'accuracy checking technician' (ACT) training course. This would allow them to conduct final accuracy checks on prescriptions that had been clinically checked and approved by a pharmacist. The pharmacy encouraged team members to provide feedback and suggestions for improvement. And the trainee ACT had suggested using a green coloured dispensing basket to highlight prescriptions that had been clinically checked and annotated by a pharmacist. This helped to keep working practices safe and helped to manage the workflow. The company distributed learnings to support team members to provide safe and effective services. For example, they had recently refreshed their knowledge and skills about the symptoms and treatments for hay fever. The pharmacy technician had introduced and was leading on regular training for the pharmacy team. And they accessed and used resources such as the company's online training modules. They had recently provided training on headaches and migraines due to the increased number of requests for advice and treatments. They kept training records and displayed training information on the dispensary wall. The pharmacy provided Post Office counter services, and team members had been trained to provide the relevant services. They also completed compliance tests on a regular basis.

The regular pharmacist had recently completed the 'pharmacist independent prescriber' (PIP) training course and had introduced the NHS Pharmacy First Plus service. A whistleblowing notice was on display for team members to refer to. And they understood their obligations to raise concerns if necessary. They knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy provided a modern, purpose-built environment from which to safely provide services. A sound-proofed consultation room with a sink was available for use. And it provided a clinical environment for the administration of vaccinations and other services such as blood pressure monitoring. The consultation room provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. Team members regularly cleaned and sanitised the consultation room and the pharmacy. This ensured they remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take comfort breaks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

A stepped entrance provided access to the pharmacy and a portable ramp helped people with mobility difficulties. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. They checked expiry dates once a month and kept audit trails to evidence when checks were next due. This managed the risk of supplying short-dated stock in error. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. The pharmacy used clear bags for dispensed items awaiting collection. This helped team members easily identify the contents.

Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug (CD) cabinets for some items. Medicines were well-organised and items awaiting destruction were kept well-segregated from other stock. Team members produced an audit trail of drug alerts. And they evidenced they had checked for affected stock so it could be removed and quarantined straight away. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. The pharmacy mostly supplied original packs which contained patient information leaflets and information cards. The pharmacy used dispensing baskets for the different types of dispensing it carried out. For example, it used larger sized baskets for dispensing multi-compartment compliance packs. The baskets helped to safely hold medicines and prescriptions during the dispensing process and managed the risk of items becoming mixed-up. The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were available for people to collect. They obtained a clinical and accuracy check at the time of dispensing. And the pharmacist carried out a final accuracy check at the time they made the supply.

The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medication. And they used a separate rear area to assemble and store the packs. Team members obtained an accuracy check before they started de-blistering medicines. This meant they were able to identify and correct any selection errors before they started dispensing. Trackers helped team members to plan the dispensing of the packs. And this ensured that people received their medications at the right time. They also used supplementary records that provided a list of each person's current medication and dose times which they kept up to date. And they checked new prescriptions against the records for accuracy. Team members provided descriptions of medicines. And they supplied patient information

leaflets for people to refer to. People collected the packs either themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns.

The pharmacy dispensed serial prescriptions for people that had registered with the 'medicines: care and review' service (MCR). The pharmacy had a system for managing dispensing. And they retrieved prescriptions every Monday so they could order items and dispense items in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. The pharmacy checked its retrieval area on a regular basis. And they removed items and contacted people when appropriate to remind them to collect their medication. This helped the team members to check compliance and contact the relevant services if they had any concerns.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacist used a blood pressure monitor. But team members were unable to confirm if the pharmacy kept calibration records. This meant they were unable to provide the necessary assurance to show the monitor was measuring accurately. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.