General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 1 High Street, BUCKIE, Banffshire, AB56 1AL

Pharmacy reference: 1041918

Type of pharmacy: Community

Date of inspection: 30/09/2020

Pharmacy context

This is a community pharmacy on the high street of the town of Buckie. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs and provides substance misuse services. This pharmacy was inspected during the COVID-19 pandemic.

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 team members follow written processes for all services to ensure that they provide them safely. The pharmacy makes suitable changes to help reduce the risks to people during the pandemic. They record mistakes to learn from them and make changes to reduce the chances of the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know how to help to protect vulnerable people.

Inspector's evidence

The pharmacy had put processes in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines counter, hand sanitiser at the premises entrance, and was limiting access to two people at a time. People coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points continuously. A team member cleaned the consultation room immediately after use. The pharmacy manager had informally carried out personal risk assessments with each team member to identify any risk that may need to be mitigated in the pharmacy. Two team members were in the shielding group so had not worked for several weeks. Another who was at increased risk avoided contact with people using the pharmacy. Initially, the two pharmacies in the company located close had worked closely together but kept two distinct teams. This meant that if anyone had COVID-19 symptoms, some team members would have to self-isolate but there was another team who could keep both pharmacies open. This strategy had not been needed. Team members were aware of their own and others' needs following the pressure on the pharmacy during the early stages of the pandemic. They had all now had a week's holiday to rest and 'recharge'.

The pharmacy had standard operating procedures (SOPs) which team members followed. They had read them, and the pharmacy kept records of this. A relief pharmacist who had worked a lot in this pharmacy had reviewed and updated the SOPs within the last year. The pharmacy manager had read and agreed them. This was an improvement from the previous inspection when historic SOPs were observed and had not been read by all team members. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The accuracy checking pharmacy technician (ACPT) carried out the final check for prescriptions that the pharmacist had clinically assessed and initialled. The ACPT had qualified within the last year, but due to processes changing throughout the pandemic, had not established checking all prescriptions yet. She was working with the pharmacist to ensure that safe processes were introduced, embedding them before adding more. For example, she did not yet carry out the final accuracy check of multi-compartment compliance packs. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had a list of useful phone numbers on the dispensary wall, including other pharmacies, healthcare professionals and suppliers.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy, known as near miss errors. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The ACPT described being much more aware of detail since she had been undertaking

accuracy checking. This had improved her dispensing accuracy. The pharmacist described always checking people's records when supplying inhalers, to ensure the pharmacy supplied the correct device. She put notes on people's records following errors, to remind her to carry out an extra check.

The pharmacy had a complaints procedure and welcomed feedback. Team members could not provide examples of complaints but gave examples of positive feedback from people. There were several 'thank-you' cards on the wall from people grateful for the service they had received during the pandemic. And local businesses had provided meals for team members acknowledging the good service they were providing while under a lot of pressure early in the pandemic, including working on a public holiday. The pharmacy continued to respond to requests from people, including ordering appropriate retail items and over-the-counter medicines. And it took items into stock when there were repeat requests.

The pharmacy had an indemnity insurance certificate, expiring 30 April 21. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log, private prescription records including records of emergency supplies and veterinary prescriptions, unlicensed specials records, controlled drugs (CD) registers with running balances maintained and regularly audited, and a CD destruction register for patient returned medicines. Team members signed any alterations to the records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read information as part of their employment contract. The pharmacy had issued all team members with a new contract since the previous inspection. And new team members were given a staff handbook which also contained information on confidentiality. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members knew how to raise safeguarding concerns locally either with the local GP practice or they had contact details for the council department.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified team members to provide safe services. They make decisions within their competence to help people. The pharmacy provides time and support during the working week for team members to complete accredited training. But it does not always set aside time for team members to continue their learning so they may find it difficult to keep their knowledge up to date. Team members know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time accuracy checking pharmacy technician (ACPT), one full-time trainee pharmacy technician, three full-time and three part-time medicines counter assistants, and three Saturday only team members. The pharmacy displayed their certificates of qualification. Typically, there were two team members in the dispensary and two on the medicines counter at most times, as there was during the inspection. One of the full-time team members worked mainly on the upper floor managing company administration and a photo-lab. Team members were able to manage the workload.

The pharmacy provided learning time during the working day for team members undertaking accredited courses with additional time to complete coursework. The trainee pharmacy technician described having regular time even throughout the pandemic, and the ACPT explained that she had time and support to complete the necessary tasks to gain her checking qualification. The pharmacy did not have any regular or structured ongoing training or development in place for team members. But they were hoping to undertake training for the Pharmacy First service soon.

Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy technicians made decisions and contacted prescribers with queries about prescriptions without being asked. They demonstrated a confident and professional manner, within their competence. One query was about the flavour of a food supplement. The prescription requested one flavour for two months' supply, and the team member thought that the person might prefer some variety. The GP practice was largely closed to the public and was only taking prescription requests online. Many people were not able to do this, so they phoned the pharmacy to order their medicines. Team members checked people's records when they phoned. They could then confirm with people if they were requesting medicines at an appropriate time. And they were empowered to arrange to provide urgent supplies of medicines, while explaining clearly which medicines the pharmacy could not supply in this way.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. Team members in the three branches in the town shared information and worked closely. Sometimes they helped in the other branches. They described feeling able to make suggestions and raise concerns to the superintendent pharmacist although they had never needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. Team members deal promptly with maintenance issues. The pharmacy has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and large upper floor area including storage space and staff facilities. The company used this area for retail and sundries' storage for all six pharmacies in the company. The premises were clean, hygienic and well maintained. Team members were observed to clean surfaces and touch points continually. And they carried out a weekly deep-clean on Saturdays. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. During the inspection the automatic door stopped working properly. A team member immediately called the superintendent pharmacist (SI) who suggested some things to try to resolve the issue. When this did not help, the SI asked the team member to call the maintenance company, and the issue was going to be resolved that day.

People were not able to see activities being undertaken in the dispensary which was in a separate room from the retail area. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The team was using this room less frequently than normal due to the COVID-19 pandemic. A team member cleaned surfaces immediately after use. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can easily use its services. It provides safe services. Team members give people information to help them use their medicines safely. And they provide extra written information to people taking higher-risk medicines. The pharmacy gets medicines from reliable sources and stores them properly. The team knows what to do if medicines are not fit for purpose.

Inspector's evidence

People accessed the pharmacy through an automatic door, and it had one step. It listed its services and could provide large print labels for people with impaired vision. The pharmacy provided a delivery service with the medicine counter assistants undertaking this following a rota. During the pandemic more people had required deliveries, so the pharmacy had increased its delivery services to five days, going to different areas on different days to be more efficient. As less people were now having to stay at home the pharmacy was trying to reduce deliveries and encourage people to come to the pharmacy where possible. Team members used a company vehicle and took items requiring cold storage first. They estimated that these medicines would typically be out of the fridge for around ten minutes. Team members described the process which had changed during the pandemic to minimise the chance of spreading infection. They did not ask people to sign to acknowledge receipt of any medicines now and observed social distancing. They sanitised their hands between deliveries and cleaned the van daily.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and to keep separate people's medicines and prescriptions. They had designated benches for dispensing and checking. And had changed these during the pandemic to enable social distancing. The pharmacist undertook clinical assessments before labelling, using the patient medication record (PMR) to facilitate this. She initialled prescriptions to confirm that she had assessed them and they were suitable to be supplied. One team member labelled, marking prescriptions if there were any new items, then another team member dispensed when possible. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The ACPT carried out the final accuracy check of some repeat prescriptions if she had not been involved in any part of the dispensing process. She also checked stock for multi-compartment compliance packs after a colleague had gathered it. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people requested them. The pharmacist regularly checked the computer records to monitor compliance. She seldom identified serious issues but raised concerns with the practice pharmacist if appropriate.

The pharmacy managed the dispensing of multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members followed a robust process and kept comprehensive records of changes and interventions. They gathered stock then a colleague checked it and kept a record of this. The pharmacist checked the completed packs. Team members included tablet descriptions on backing sheets. They ensured they were always accurate regardless of brand of tablet used. They stored completed packs tidily on shelves in the dispensary and marked them for delivery or collection. The pharmacy supplied patient information leaflets (PILs) unless people had requested not

to have them. Team members printed additional PILs from EMC (electronic medicines compendium) when required. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed them on Saturdays for supply the following week. And labelled them with the date of dispensing and the date of supply. This made it clear when the instalment had been supplied. Then placed them on a designated shelf with the day of collection marked. The pharmacy also supplied medicines administration (MAR) charts to people on the medicines' management service. Team members had reviewed and improved this process since the previous inspection. They now printed the MAR sheet when carers came to the pharmacy to ensure the start date was correct. Previously some people had been confused as the date was the date of printing which was often a few days before the pharmacy made the supply. And if the dates on the MAR chart were not correct, carers could not administer medicines to people. The pharmacist supervised consumption of some medicines in the consultation room. She placed the instalment on a table then stepped back while the person stepped forward to pick the bottle up. After consumption, people placed their empty bottles directly into a bin for secure destruction. This was observed and social distancing was maintained. A team member immediately cleaned the surfaces and the pharmacist washed her hands.

The pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It did not supply valproate to anyone in the risk group. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle. Team members gave verbal and written information to people supplied with these medicines over the counter, or on prescriptions. They also discussed 'sick day rules' with people on certain medicines, so that people could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy's labels were now automatically populated with this information for relevant medicines. Team members removed this information in certain circumstances. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. The pharmacy was in the early stages of implementing the Pharmacy First service and once trained, team members would be empowered to deliver it. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

During the pandemic the pharmacist had conducted consultations by phone for services such as the supply of emergency hormonal contraception (EHC), treatment of urinary tract infections (UTI) and smoking cessation. The pharmacy had updated its Facebook page and explained that for infection control and to reduce time that people spent in the pharmacy, it preferred these conversations by phone.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on the premises. But team members had not had any training yet. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges and team members monitored minimum and maximum temperatures. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The pharmacy had continued to accept unwanted medicines from people throughout the pandemic. Team members quarantined items if appropriate, wore PPE and washed and sanitised their hands after handling them. They stored the medicines in an appropriate receptacle until

the NHS waste contractor uplifted it.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. And it looks after the equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. The pharmacy kept a carbon monoxide monitor maintained by the health board in the consultation room where it was usually used with people accessing the smoking cessation service. But during the pandemic team members did not use this equipment in the interest of infection control. Team members kept ISO and crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They washed them immediately after each use. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and consultation room inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.