General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 3a Union Street, PORTKNOCKIE, Banffshire, AB56 4LF

Pharmacy reference: 1041927

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

This pharmacy is in the coastal village of Portknockie and also operates as a newsagent for the village. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy offers the NHS Pharmacy First service which provides people with access to a range of medicines to treat a variety of minor ailments.

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 suitably identifies and manages the risks associated with its services. It keeps the records it needs to by law and it protects people's private information. Team members have training to help them appropriately manage safeguarding concerns. They respond appropriately when errors happen and they mostly act to prevent future mistakes. But they do not keep records of all types of errors so they may miss opportunities to learn and improve the safety of services.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically and were updated by the team at head office. These provided the team with information to perform tasks supporting the delivery of services. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The team received notification when new SOPs were released or changes were made to existing ones.

The pharmacy had procedures to manage and record errors spotted during the dispensing process known as near miss errors. And it had separate procedures for errors that were identified after the person received their medicines, known as dispensing incidents. The procedures included keeping a record of the near miss errors. The pharmacy had a template to capture these errors but no records had been made. The pharmacist dispensed and checked her own work. To reduce the risk of errors she took a mental break between dispensing and checking the prescription. And she usually dispensed the prescriptions one day and checked them the next day. The pharmacist described one or two occasions when she'd spotted an error when checking what she had dispensed but hadn't recorded it. And acknowledged this would help her learning and reduce errors. The pharmacist recorded dispensing incidents on to the pharmacy's electronic patient medication record (PMR). She described her learning from an incident when she'd added incorrect dose instructions to the dispensing label. This included asking the person to confirm the dose they were expecting. And checking this against the prescription and the label at the point of handing the medication over. The Superintendent Pharmacist (SI) and head office team collated information from the errors reported across all the pharmacies in the company and shared key learning with all teams.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. There was no information in the pharmacy to provide people with details on how to raise a concern or provide feedback. The pharmacy website had a section for people to answer a few questions about their experience of using the pharmacy.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the RP records and controlled drug (CD) registers met legal requirements. The pharmacy did not display details on the confidential data kept and how it complied with legal requirements. The pharmacy website displayed a privacy notice. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The RP was registered with the protecting vulnerable group (PVG) scheme and had access to contact numbers for local safeguarding teams. The pharmacist liaised with the local GP when concerns about a person arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the appropriate qualifications and skills to support its services. Team members support each other in their day-to-day work. And they receive support from other teams in the company. The team members have opportunities to receive feedback on their performance and they undertake ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

A full-time pharmacist manager, a regular relief pharmacist and a medicines counter assistant (MCA) covered the pharmacy's opening hours. The pharmacy also had a part-time delivery driver. The MCA had enrolled on to a pharmacy stock control course to support the pharmacists in the dispensary. The pharmacy had limited opening hours which had been agreed with the NHS. This enabled the pharmacist manager to work at this pharmacy and another in a nearby village for a few hours a day.

The pharmacist manager used the chat function on a social media platform to communicate with other pharmacists in the company and regional managers. This helped her keep up-to-date and to reach out to others when she had a query. The pharmacy provided online training for the team and the pharmacist received informal feedback on her performance and support from the head office team. The MCA was provided with support from the pharmacist manager and had protected time to complete the training course. The pharmacist manager kept her knowledge and skills up to date as part of her professional revalidation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and generally suitable for the volume of services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The dispensary was very small with limited space to work and store medicines. The pharmacist manager kept the dispensary tidy and created some room to dispense and check prescriptions. The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacist kept the floor spaces clear to reduce the risk of trip hazards. The pharmacy team asked the delivery drivers from the wholesalers to empty the boxes containing the stock into one box so there was less of them in the dispensary.

The pharmacy had a part-time NHS contract for dispensing NHS prescriptions and provided other pharmacy services such as the sale of over-the-counter P medicines during the limited hours. The small range of P medicines were stored in the dispensary.

The pharmacy had a soundproof consultation room which the pharmacist used for private conversations with people and when providing the pharmacy services. The pharmacy had restricted public access to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a small range of services that supports local people's health needs. It generally manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The pharmacy team generally carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

The pharmacy provided its services against a part-time NHS contract. The reduced opening hours were displayed on the front door but not on the pharmacy's website. The notice on the front door also provided an out of hours telephone number. The pharmacy delivered the NHS Pharmacy First service which was popular and provided treatments for a range of medical conditions including uncomplicated urinary tract infections. The pharmacist worked with up-to-date patient group directions (PGDs) that gave the authority to supply prescription only medicines (POMs).

The pharmacy offered a few people help with taking their medicines by arranging for their medication to be in multi-compartment compliance packs. The dispensary was small with limited space to work and as the number of people requiring compliance packs increased the pharmacist recognised she could not support the service on her own. The pharmacist liaised with colleagues at head office to transfer, with people's consent, most of the compliance packs to another pharmacy in the company that had capacity to provide this service. The packs contained the descriptions of the products within the packs and people were supplied with the manufacturer's packaging information leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy provided a repeat prescription ordering service for people. The pharmacist emailed the repeat prescription requests and used the email chain as a record of the request.

The pharmacy supplied medicines to a few people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacist provided people with clear advice on how to use their medicines. The pharmacist was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and provided appropriate information to the people prescribed the product. The prescriptions for valproate captured the date the person had a review with the prescriber which the pharmacist made a note of so she could speak to the person to confirm the review had taken place.

The pharmacist usually used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources. The pharmacist manager occasionally checked the expiry dates on stock but didn't keep a record. The pharmacist didn't mark medicines with a short expiry date to prompt a check of the medicine to ensure it was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so the pharmacist could assess if the medicines were still safe to use. The pharmacist

manager checked and recorded fridge temperatures each day. A sample of these records found they were some occasions when the temperature was outside the correct range. The pharmacist had reported this to the company head office team. The pharmacy stored controlled drugs (CDs) in a CD cabinet that met legal requirements. The pharmacy used medicinal waste bins to store out-of-date stock and patient returned medication and it had appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The pharmacist manager usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy had a domestic fridge for storing medicines that needed to be kept at these temperatures. The fridge had not kept the correct temperature on a few occasions but was correct at other times. The pharmacist manager had reported this to the head office team. The pharmacy computer was password protected and the team stored completed prescriptions and other confidential information in the dispensary which had restricted public access.

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.