General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicines Pharmacy, 23A Clifton Road, LOSSIEMOUTH, Morayshire, IV31 6DJ

Pharmacy reference: 1042790

Type of pharmacy: Community

Date of inspection: 22/07/2024

Pharmacy context

This is a community pharmacy in the coastal town of Lossiemouth. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service. The pharmacy team advises on minor ailments and the pharmacist provides the NHS Pharmacy First Plus service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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	4.2	Good practice	The pharmacy provides a prescribing service working closely with the local GP practice. It uses shared records which allows appropriate checks to be made when deciding on the best treatment for people. And the pharmacy demonstrates how this results in positive outcomes for people using the pharmacy.
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. They make records of mistakes and learn from them. And they review the pharmacy's processes and procedures and take the opportunity to improve the safety of services. The pharmacy keeps the records it needs to by law, and it keeps people's private information safe. The team is adequately equipped to manage any safeguarding concerns.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs), and team members had read and agreed to follow them. The SOPs included the Responsible Pharmacist (RP) regulations, handling controlled drugs (CDs) and safeguarding vulnerable groups. SOPs had been reviewed by all team members in April 2024. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for branch closure when there was no responsible pharmacist available.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month and discussed these as a team to learn from them. Records documented the strategies they had implemented to minimise the chances of the same error happening again. For example, there had been mistakes made with diabetic medicines which had similar names. The team had separated these in the drawers and highlighted the storage locations so that they took extra care when they dispensed these medicines. And they maintained a list of medicines with similar looking packaging for team members to refer to. The pharmacy advertised its complaints procedure in the retail area and welcomed feedback. Team members felt confident to manage complaints and knew to provide the contact details for the pharmacy's head office if they could not resolve issues in the pharmacy. People using the pharmacy on the day of the inspection shared their positive experiences with the inspector.

The pharmacy had current professional indemnity insurance. The pharmacy displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept digital CD records with running balances. A check of the physical quantity of three randomly selected controlled drugs matched the balance recorded in the register. Stock balances were checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. The pharmacy displayed a notice in the retail area about how they processed people's personal data. Team members separated confidential waste for shredding. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered

with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people this in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. They feel comfortable giving feedback and suggesting improvements to provide a more effective service. And the pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence

Inspector's evidence

On the day of inspection, the RP was the regular pharmacist manager. They were supported by two full-time dispensers, one part-time dispenser and a part-time medicines counter assistant. A further part-time dispenser was not working on the day of inspection. All team members had completed an approved training course relevant to their role. Team members were given time during working hours for ongoing learning. They accessed a variety of different learning resources. Recent learning had included reading new SOPs and learning about new services.

Team members were seen to be managing the workload. Those spoken to during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They were seen to give appropriate advice to people in the pharmacy. And they referred to the RP for further clarification when needed. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. Team members knew what tasks could not be completed if the RP was not in the pharmacy. Part-time team members could work extra hours if required to cover absences. And team members from a nearby pharmacy owned by the same company could provide cover if required for unexpected absences.

Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members were due to have an annual appraisal in the days following the inspection, and some team members were completing feedback forms during the inspection in preparation for their appraisals. They also had informal team discussions during the course of their usual work. Team members expressed how they felt able to make suggestions and raise concerns with the pharmacist manager or head office support team if they needed to. The pharmacy had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, secure, and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy premises comprised of a small retail area, dispensary and a back shop area which included staff facilities. The premises were clean, hygienic and well maintained. Seats were provided in the retail area for people waiting on prescriptions. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People in the retail area were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room which was clean and tidy, and contained a desk, chairs and a sink. The door closed which provided privacy. It provided a suitable environment for consultations and other services. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. It works effectively with other healthcare teams to help achieve positive health outcomes for people. The pharmacist uses shared medical records when prescribing to help make sure people receive the most appropriate treatment. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a power-assisted door. The pharmacy advertised some of its services and its opening hours in the main window. It displayed posters and leaflets which provided information on other services such as support groups for fibromyalgia. Team members described how they supported people with a hearing impairment access the pharmacy's services. This included the use of basic British Sign Language and supportive written communication. All team members wore badges showing their name and role.

The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The pharmacist was an independent prescriber (PIP) and provided the NHS Pharmacy First Plus service. They treated several common clinical conditions including those affecting the ear, nose and throat. They were trained to carry out clinical examinations and worked to a national service specification and prescribed to a local formulary. They used NHS prescriptions with a unique prescriber number so their prescribing activity could be reviewed and audited. The pharmacist kept detailed records of consultations. The local GP practice was supportive of the service and signposted people to the pharmacy when appropriate. The pharmacy worked closely with the GP practice and had been provided remote access to the local GP medication records. Access to information on this system was restricted, so the PIP could review records of blood tests and people's medical history but not GP consultation notes. This allowed the pharmacist to access appropriate additional information required to prescribe effectively. And the system allowed the pharmacist to add their consultation notes and medication prescribed directly into people's records which avoided any delay in prescribing information being recorded. The pharmacist demonstrated several records of consultations where they had altered their initial prescribing decision based on the additional information accessed on the GP records. And examples of referrals back to the GP when the information accessed suggested people required GP review. The pharmacist also provided this service privately to people who were not eligible for the NHS service. This was particularly useful for people visiting the area. The pharmacist recorded consultations in the same way and created a signed private prescription on a template form.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy provided a delivery service, provided by a delivery driver shared with the

company's other pharmacy in the town. A team member entered the day's deliveries onto an electronic platform which the delivery driver used to record when medication was delivered. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply. Team members regularly checked prescriptions with owed medication and requested an alternative from the person's GP when required.

The pharmacy provided many people with their medication using 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these a week in advance of when people would collect them. Team members checked with people if they required all of the medication on the prescription before they left the pharmacy. They updated the PMR and returned items which were not required to the dispensary to avoid waste. They maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately.

The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person for each week of assembly. These master sheets documented the person's current medicines and administration time. And team members made records when there were changes to people's medication, creating an audit trail. Packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. And team members provided people with patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in drawers. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines and kept records of these checks. They highlighted medicines expiring in the next three to six months for use first. A random selection of medicines inspected were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done. 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 to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had access to the internet and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a blood pressure monitor, stethoscope, pulse oximeter and otoscope. Equipment was appropriately maintained. Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. And they kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records securely in the dispensary inaccessible to the public. Computer screens were positioned to ensure people couldn't see any confidential information. The pharmacy had cordless telephones and team members were observed moving to a quieter area of the pharmacy to have private conversations with people.

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.