General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Right Medicine Pharmacy, Station Road, KYLE, Ross-Shire, IV40 8AE

**Pharmacy reference:** 1042855

**Type of pharmacy:** Community

**Date of inspection:** 25/04/2019

## Pharmacy context

The pharmacy is in the village of Kyle of Lochalsh which lies 63 miles west of Inverness. It is next to the Skye bridge and the train station to Inverness. A sister branch is on Skye which is a 15-minute drive away. The upstairs section of the premises is used to dispense NHS prescriptions and provide a range of additional services. The downstairs retail area is used for a range of toiletries and gifts. Both areas are accessed via separate power assisted doors. The pharmacy supplies medicines in multi-compartment medicine devices when people need extra support. And a consultation room is available for people to be seen in private.

## 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 complete training and work to professional standards. They provide safe services and look after people. The pharmacy keeps records of mistakes when they happen. And senior pharmacy members carry out checks to make sure the pharmacy is running safely. The pharmacy updates its processes and procedures so that services remain safe and effective. The pharmacy keeps the records it needs to by law. It understands its role in protecting vulnerable people. And it provides regular training to keep confidential information safe. People using the pharmacy can raise concerns. And staff know to follow the company's complaints handling procedure. This means that staff listen to people and put things right when they can.

### Inspector's evidence

A regular pharmacist manager had been in post for three years. The pharmacist displayed the responsible pharmacist notice. And people could identify who was in charge.

The standard operating procedures defined the pharmacy processes and staff responsibilities. The pharmacy team had not signed to confirm they had read the standard operating procedures. This was due to them being introduced in March 2019.

The pharmacy team signed prescriptions to show they had completed a dispensing activity. This included assembly and accuracy checking prescriptions. The pharmacist checked prescriptions. And gave feedback to dispensers when they failed to identify their own errors. The pharmacist recorded the near-misses. But did not always identify the contributing factors. This meant that improvement action was not always identified and discussed.

Sample near-miss reports were selected for January and February 2019. The pharmacist had identified similar packaging, mis-read prescriptions and distractions as causes of near-misses in February 2019. And had documented the need to check similar packaging and separate strengths. The pharmacy team were unable to provide examples other than separating Pulmicort turbohalers to manage selection risks. The pharmacist had identified similar packaging and calculation errors in January 2019. And had instructed staff to obtain a second accuracy check from a colleague. The pharmacy team had agreed to mark broken packs to avoid quantity errors.

The pharmacy technician knew about the superintendent’s quarterly newsletter. This provided the opportunity for the pharmacy team to learn about risks and service improvement. The pharmacy technician could recall an incident when another branch had to call an ambulance for a highly intoxicated individual. And had reflected on the administration of naloxone should the need arise.

The pharmacist managed the incident reporting process. The pharmacy team knew when incidents had happened and what the cause had been. For example, when a multi-compartment medicine device had been issued to the wrong person. The pharmacist had reminded the pharmacy team to ask people to confirm their name and address before making a supply.

A complaints policy ensured that staff handled complaints in a consistent manner. This increased the likelihood of the pharmacy team being able to resolve issues. And managed the need for people to escalate complaints. A notice informed people about the complaints process and provided contact details. A counter assistant had invited a wheelchair user to provide feedback about accessibility. This had resulted in hangers in the retail area being shortened, and gondolas being moved to improve access.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy team kept the electronic controlled drug registers up to date. And checked and verified the balance of controlled drugs once a month.

The pharmacy recorded controlled drugs that people returned for destruction. The staff destroyed the controlled drugs on a regular basis. And recorded their names once completed. A sample of private prescriptions were up to date and met legal requirements. A sample of specials records were up to date. And the pharmacy team recorded the name of the person who had received the medication.

The pharmacists used patient group directions to improve access to medicines and advice. A sample varenicline patient group direction was valid until 2019. But, the full date was not provided on the document.

The pharmacy team were expected to read and sign a 'patient confidentiality and consent' standard operating procedure. And knew to comply with data protection requirements. The pharmacy team disposed of confidential information using a shredder. And a collection service for off-site shredding was also available should it be needed. The pharmacy team archived spent records for the standard retention period. The pharmacy stored prescriptions for collection out of view of the waiting area. And computer screens were not visible. The pharmacy team took calls in private using a portable phone when necessary. A password was used to restrict access to patient medication records.

The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the pharmacist had been registered with the scheme. The pharmacy team were expected to read and sign a child protection and vulnerable groups standard operating procedure. And knew to raise concerns when they recognised the signs and symptoms of abuse and neglect. The pharmacy team were aware of vulnerable groups. And key contact details were available should a referral be necessary. The pharmacy technician provided an example when she had agreed to supply a multi-compartment medicine device. And had contacted the GP when the devices had not been collected.

Public liability and professional indemnity insurance were in place and expired on 30 April 2019.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And provides access to ongoing training. The pharmacy could improve upon the uptake of learning with closer monitoring. The pharmacy team members support each other in their day-to-day work. They can speak up and suggest service improvements.

### Inspector's evidence

The pharmacy work-load had remained stable over the past year. The pharmacist had carried out a staffing review due to a member of staff taking extended leave. This confirmed that a replacement was needed. And a new member of staff had been recruited.

The pharmacy kept staff qualifications on-site so that evidence of accreditation was available. The pharmacy team members were mostly long-serving and experienced. And the following staff were in post: one full-time responsible pharmacist who had worked at the pharmacy for around three years; one full-time pharmacy technician; one full-time trainee dispenser; one full-time medicines counter assistant; one part-time medicines counter assistants and two part-time trainee medicines counter assistants.

The pharmacy allowed one member of staff to take annual leave at the one time. And the trainee dispenser provided cover when the pharmacy technician was off. A sister branch was located approximately nine miles away. And staff could be called on to provide cover when necessary. A pharmacist who also worked at the sister branch provided regular cover.

The pharmacy supported staff that were in training. And the pharmacist had agreed protected training time for the trainee dispenser. The pharmacy had provided a mentor for each of the trainees. And had arranged training material to be provided in a different coloured font for one of the trainees due to her not being able to read standard print.

The pharmacy team knew about the company targets that were in place. But did not feel under pressure to meet the targets. And knew only to register people that were suitable for each service.

The pharmacy used a quarterly performance review to develop staff. For example, the pharmacy technician had agreed to support the trainee dispenser who needed to develop the competencies required to work in the dispensary. The pharmacy provided e-learning and the pharmacy team were encouraged to learn. But, there was little evidence to confirm this was being used. An experienced counter assistant kept up to date with changes and new products. For example, a pharmacy representative had provided an update on antihistamine sprays. The pharmacy had recently introduced individual training records. But, only the pharmacy technician had made an entry to reflect recent training. The pharmacist had attended a training session organised for managers in the NHS Highlands

area. This was delivered by the Advisory, Conciliation and Arbitration Service (ACAS). And included information about disciplinary processes.

The company invited the pharmacy team to attend its annual conference. And a few members of staff had attended and updated the rest of the team on their return. Guest speakers provided training in relevant subjects. For example, eye conditions and products that could be used to treat them. The pharmacy team had also learned about how to deliver good customer service.

The pharmacy team members raised concerns and provided suggestions for improvement. For example, the pharmacy technician had re-organised a section of the pharmacy that was used to store dressings due to congestion. And had contacted the district nurses at the local surgery to provide details of stock held to avoid wastage.

The pharmacist discussed queries with patients. And gave advice when handing out prescriptions.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are clean. And provide a safe, secure and professional environment for patients to receive healthcare.

### Inspector's evidence

The pharmacy maintained and cleaned the premises on a regular basis. And a large well-kept waiting area presented a professional image to the public. The pharmacy provided seating in the waiting area. And a range of patient information leaflets were available for self-selection. A consultation room was available and professional in appearance.

The pharmacy had allocated bench space for the different dispensing tasks. The pharmacy team dispensed walk-in prescriptions near to the waiting area. And dispensed multi-compartment medicine devices on an allocated section of bench.

The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed. A security alarm protected the pharmacy after hours. And panic buttons were available.

The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy offers a range of services to the surrounding area. It provides information leaflets for self-selection. And displays opening times and service information in the window. The pharmacy supports vulnerable people. And dispenses multi-compartment medicine devices for people who need extra help. It supports its local community. And stocks a wide range of healthy living products. The pharmacy manages its services and updates the pharmacy team about high-risk medicines. This means that staff are up to date with current safety messages. The pharmacy sources, stores and manages medicines to ensure they are fit for purpose. And it has the capability to follow the new falsified medicines directive.

### Inspector's evidence

The pharmacy had two separate entrances. And people with mobility difficulties could access both entrances on a level surface. Two power assisted doors were available to provide extra support. A new handrail had been recently installed to provide support to people using the stairs between the pharmacy and a downstairs retail area. The pharmacy displayed its opening hours at the front of the pharmacy. And service information was available.

The pharmacy stocked a wide range of products and responded to local demand when possible. This sometimes avoided the need for people to travel to Inverness, which was a two-and-a-half-hour rail or bus journey away.

The pharmacist wrote messages on prescription bags. For example, the letter P was being added to remind the medicines counter staff to obtain two signatures when they collected pregabalin due to its new controlled drug status; a controlled drug label was also being added.

The medicines counter assistants managed the retail section. For example, they kept a small library of used books that had been handed in. The books were sold, and the proceeds donated to charities or local causes. For example, a local drama group were given money to purchase stage lights. And these were also used by the local school.

The dispensing space was adequate. And bench space was allocated for the various dispensing tasks. The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process.

The pharmacist referred people to the GP when issues were identified. For example, when someone taking cholesterol lowering medication was prescribed antibiotics. And the person was advised to stop taking their statin until the course of antibiotics was completed.

The pharmacy provided multi-compartment medicine devices for people who needed extra support. The pharmacy team used trackers to manage the work-load. This avoided people going without their medication. The pharmacy team recorded changes on each patient medication record sheet. And

changes were only actioned on receipt of a written request from the surgery. The pharmacy team supplied patient information leaflets and descriptions of medicines. And supported people using the devices.

The pharmacy team kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The stock levels were kept high due to potential disruptions on the road. For example, due to adverse weather conditions. The pharmacy kept a business continuity plan up to date. And this could be used in the case of an emergency. A sister branch was in Broadford approximately nine miles away. And stock was shared when necessary.

The pharmacy kept controlled drugs in organised cabinets to avoid selection errors. For example, the pharmacy team used a separate cabinet to store expired medications. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs. They monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees.

Staff accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. For example, the pharmacist could recall checking for stocks of losartan in February 2019 with none found. But, the outcome and date of check was not always retained. The pharmacist had briefed the pharmacy team about the use of valproate in women. And they knew about the pregnancy protection scheme and where to find safety leaflets and cards. The pharmacy team knew they dispensed prescriptions for two patients in the at risk group. And knew they were unaffected due to their age. But, the pharmacy team continued to add warning labels.

The pharmacy had developed standard operating procedures and had trained staff to follow the falsified medicines directive. And although it had installed a bar-code reader and associated software, the system had not been operationalised.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services.

### Inspector's evidence

The pharmacy used CE quality stamped measures for measuring liquids.  And counting triangles were available. Cleaning materials were available for hard surface and equipment cleaning. And hand washing equipment was also available. The pharmacy sink was clean and suitable for dispensing purposes.

References sources were available. For example, the current copy of the BNF and the BNF for children were in use.

A consultation room was used. And the pharmacy protected people's privacy and dignity.

## 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. |