General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 77-79 High Street, SELKIRK, Selkirkshire, TD7 4BZ

Pharmacy reference: 1042968

Type of pharmacy: Community

Date of inspection: 06/11/2019

Pharmacy context

The pharmacy is in the centre of a small market town. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And provides advice on the management of minor illnesses and long-term conditions. It delivers medicines to people's homes. And supplies medicines in multi-compartment compliance packs. These help people remember to take their medicines. The pharmacy provides NHS services including the treatment for urinary tract infections. And impetigo and 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	1.2	Good practice	The pharmacy team members continually monitor and review processes to identify and deliver improvements in the safety and quality of services. And consistently review and learn to improve.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages and supports the pharmacy team to learn and develop. And it engages its team members in regular learning to develop their skills and knowledge to help improve services.
		2.4	Good practice	Pharmacy team members are committed to working in an environment of openness and transparency. And they work together to support learning and development.
		2.5	Good practice	The pharmacy team members feel comfortable raising concerns and make suggestions to improve the running of the pharmacy. This helps support the safe and efficient delivery of the pharmacy services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy has robust processes in place to help identify and manage the risks associated with providing its services. And it ensures that people receive their medication with the required advice and support.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. They continually monitor and review processes to identify and deliver improvements in the safety and quality. The team members responsibly discuss mistakes they make during dispensing. And consistently review and learn to improve. The pharmacy keeps all the records, as required by law in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members have read and signed. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing of prescriptions and controlled drugs (CD) management. These were subject to regular review. The company had reviewed some in March 2019 with a review date of 2020 and others had a review date of 2021. The company sent the revised SOPs out in batches to the pharmacy for the team to read and for it to confirm the members had read them. The team advised of their roles and what tasks they could do.

The pharmacy had two terminals in the main dispensary and one for the compliance packs. The pharmacy workflow provided different sections for dispensing activities with benches for assembly and checking, with a separate area for compliance pack preparation. The team utilised the space well. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for people waiting and calling back. And white for longer call backs and other colours for repeats. This distinguished people's prescriptions by degree of urgency and this helped plan workload.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these on a specific template. Examples included the wrong quantity for metformin, with a comment that the split box had only been crossed on one side. And levothyroxine 50mcg with 25 mcg given and a comment that there was more than one strength on the prescription. The team members logged these on to paper and then transferred them to the computer. They had only recently started to record these on the computer. The pharmacist discussed the near miss at the time or discussed with the individual as soon as possible.

The pharmacist held a weekly meeting to discuss near misses and other issues. The pharmacist used a safer care review process monthly for further discussion. Points noted were to take care with pregabalin and gabapentin, antibiotic boxes with the sane sized box for 28's and 56's. It also specified the common Look-Alike Sound-Alike errors, strength errors and formulation errors. The company provided a newsletter each quarter and it shared examples from other branches for learning. The company had raised an issue when it had stopped using plastic bags for environmental reasons, but it had reinstated the use of these. This was because the pharmacy had stopped using clear bags for insulin

items and the previous extra check missed. So now bags the team used clear bags again and reused to save wasting them.

The pharmacy had a notice displayed in the pharmacy which explained the complaints process. And provided contact details. The pharmacy had an incident report SOP. The team members explained what they would do if they became aware of a complaint. The SOP had contact details for the team to contact people for advice, including the superintendent (SI) pharmacist. The pharmacy had current indemnity insurance with an expiry date of 30 April 2020.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records on the computer. The pharmacy kept electronic CD registers. It undertook a full audit once a month. The team recorded the date of the shortest expiry date for all CDs during the running balance checks which they advised was useful when items were near expiry date. A sample of the CD registers looked at were completed as required. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. It kept records for private prescriptions electronically and recorded reasons for emergency supplies as required. It kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed a Fair Processing notice on how it looked after confidential data and how it complied with legislation. The team had General Data Protection Regulation (GDPR) information. And had received updates from the head office with changes to practices at the time it came in to force. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. It kept patient sensitive information securely. The pharmacy team stored confidential waste in separate bags for offsite shredding.

The team had a standard operating procedure for Safeguarding of vulnerable groups. It had a flow chart with the process and contact numbers for local safeguarding were available for the team. The pharmacist had undertaken training through NHS Education Scotland (NES) for safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And the team members help each other in their day-to-day work. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The team tailor training to their needs to improve the service to people using the pharmacy. The team members share information and learning. So, they can improve their performance and skills. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT), three, dispensers and one medicines counter assistant (MCA) who worked in the pharmacy. The ACT worked 38 hours a week, the dispensers worked between 30 and 40 hours a week and the MCA worked 37 hours a week. The pharmacist had second pharmacist cover one day a week. This allowed additional tasks to be undertaken. This included the newly implemented Health Board Medicine Review service which some pharmacies were taking part in. It also allowed for focus on other services and preparation for the multi-compartment compliance packs.

Certificates and qualifications were available for the team. And displayed at the counter. One certificate for a member of the team was for long service, 35 years. And one was for 100 per cent attendance in a year. One dispenser had completed the dispensing course and was now undertaking the counter course. One dispenser had signed up to do a First Aid course. The team also had one to one training with the surgery on asthma technique to support the Borders review for asthma.

The pharmacy had a training rota. It had recently introduced a new training process using the National Pharmaceutical Association (NPA) hub. The team members had training records. A dispenser showed her records. These showed a log of training undertaken, hours completed and the test scores. The hub had learning videos and tests which the team could complete. The dispenser had undertaken a module on hay fever and Syndol. And explained that if the pharmacy had any request from a customer they could look on the hub to see if there was any more information around the topic, so they could improve their knowledge relevant to the people using the pharmacy. The hub had training set out for various roles. And the company encouraged the dispensers to do training for technicians if they felt it was beneficial. The team all shared key learning and advised each other if there was a good topic to complete. They helped each other to fill in any gaps in knowledge. The company had an annual pharmacy conference which most of the team attended. And shared learning at the conference. The company provided a quarterly newsletter with general updates. The pharmacist had completed training for services such as the Borders Medicines Review service. The team had received the safety culture cards for discussion from NHS Education Scotland (NES. And advised this had instigated discussion in the pharmacy.

The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. The MCA following the sales of medicines protocol when making over-the-counter (OTC) recommendations and referred to the pharmacist when necessary.

The team members received performance reviews which gave the chance to receive feedback and discuss development needs. They could indicate if they wanted any further training. The dispensary team worked closely together, and the dispenser said they could provide feedback about the pharmacy or make suggestions for improvement. The pharmacist used a clip board, and everyone could write any comments or items they wished to discuss at weekly meetings. One of the team had suggested a separate file for controlled drug (CD) delivery sheets to improve the audit trail. And another had noted the change in pack sizes for valproate and added this to alert the team. The pharmacist had added a reminder to put dates on split bottles containing liquid medicines and that there was new guidance for stoma prescribing. The pharmacy filed the notes each month for reference for the team.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist or the superintendent (SI). There was a formal whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The pharmacy had recently extended in to a room at the rear of the building. And the team used this room for the preparation of the compliance packs. Another room had been refurbished and this was being used as the consultation room. The consultation room was a good size and displayed a notice informing people about the chaperone policy. The team kept the room locked when not in use.

The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team kept a cleaning rota to ensure they maintained this. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards.

The room temperature was comfortable, and the pharmacy was well lit. People could not access the dispensary due to the layout of the counter. And there always being cover for the counter. The dispensary team could also see people coming into the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. The pharmacy has robust processes and systems in place to help identify and manage the risks associated with providing its services. The pharmacy team members take steps to identify people taking some high-risk medicines. And they ensure that people receive their medication with the required advice and support. The pharmacy gets its medicines from reputable sources. And it has systems in place to ensure medicines are safe and fit to supply. It delivers medicines to peoples' homes. And it provides medicines in multi-compartment compliance packs. These help people remember to take their medicines correctly.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible. There was a small step at the entrance. There was a buzzer at the door and people could press for assistance and the team helped them if required. There was some customer seating. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. The pharmacy had a range of health-related leaflets for people to take. And had a wider range in the consultation room which the team could give to people. The pharmacy had a defined professional area. It sold a mixture of healthcare related items, toiletries and gift items. The pharmacy kept pharmacy medicines behind the counter and the team assisted people if they wished advice and to purchase these items. The team signposted to other healthcare services and had information such as a Borders therapies booklet which had supporting healthcare organisations in the Scottish Borders.

The pharmacy had around 300 people registered on the chronic medication service (CMS) and carried out reviews as required. About 100 people received serial prescriptions. The pharmacist completed Medicine Reviews which had been recently introduced in the Borders region. The reviews included asthma. These included a full review to ensure people were using their inhalers correctly and checking people were attending the clinic appointments as required. The pharmacist sent detailed reviews to the surgery once they had completed them. This included their inhaler technique maximised, adherence discussed, any issues raised and if there was any further action required. The pharmacist also undertook reviews for chronic pain and medicine sick day rules. The reviews included advice on healthy living. And the pharmacist referred to the doctor if required. The pharmacist went over the medicines affected by sickness and provided advice when to commence taking these again. The pharmacist gave card with details to remind people of the medicines to stop taking. The reviews allowed discussion on issues such as side effects and any problems taking medicines. The team were having training on blood pressure monitoring as they were going to start this service once they had developed the standard operating procedure (SOP).

The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and paracetamol post vaccination. The pharmacy empowered team members to deliver the electronic minor ailments service (eMAS) within their competence under the pharmacist's supervision. 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. The pharmacy offered a substance misuse service to around nine people. The pharmacist made up the supplies weekly ready for collection. All people were supervised on the day of collection.

The pharmacy had a good relationship with the surgery. The pharmacist kept a clip board and made any notes to pass to the practice pharmacist. The pharmacist used unscheduled care to synchronise medicines sometimes but ongoing issues she notified to the practice manager. She had noticed a patient was getting 56 of two different strengths of medicines but only taking the different strength on alternate days. So only needed 28 to keep the qualities in line with the other medicines. She also highlighted other prescriptions with quantity issues to bring them into line. This helped people manage their medicines better as they were all synchronised.

The pharmacy supplied medicines to around 96 people in multi-compartment compliance packs to help them take their medicines. The pharmacist carried out an assessment with the person requesting the pack and occasionally went to people's homes to undertake this. If suitable the pharmacist informed the doctors and they and provided authorisation with prescriptions for weekly compliance packs. One dispenser did two weeks of packs and another two dispensers did the other two weeks. The local surgery provided the pharmacy with a new list of people's medicines following any changes. The pharmacy had profile sheets for all people and updated these with any changes. The team provided patient information leaflets (PILs) with the start of each cycle. The dispensers had prepared a folder with PILs for the medicine in bulk containers to enable the pharmacy to provide these. The team included descriptions of medicines. The team kept a tracker with an audit trail of who was involved in each stage of the process. They usually prepared four weeks packs together unless people were not stable on their medicines. They had one patient who was on a weekly reducing dose with a controlled drug (CD), so they made this up each week as required. The accuracy checking technician (ACT) checked some packs.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The pharmacist marked prescriptions to indicate that she had clinically checked them. This allowed the accuracy checking technician to do the accuracy check. The team members initialled at the top of the prescriptions if they had handed out the prescription items. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out.

There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that some medication required to be added to complete the supply. The CD stickers recorded the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. The team members double signed CD prescriptions for an extra check. The team marked dates on the 'Pharmacist advice' stickers of medicines which people had not collected as expected such as inhalers. They then went over the dose with the person to ensure that they were using as required. The pharmacist had an additional slip of paper she provided to people on reducing dose for prednisolone as an extra aid.

When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept one slip with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers for an alternative if items

were unobtainable at the current time. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They had undertaken an audit, with one person in the at-risk group. They explained the information they provided to the 'patients in the at-risk' group. They had supporting cards and booklets which they provided. The pharmacy provided deliveries to people. It kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items with red dots and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy obtained medicines from reputable sources. The company were looking into the requirements for the Falsified Medicines Directive (FMD). And the pharmacist thought they had been testing in other pharmacies. But this pharmacy had no implementation date yet.

The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. These were put on the clip board to alert all the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. The team members cleaned triangles after use. The team members had access to disposable gloves and alcohol hand washing gel.

The pharmacy sent the carbon monoxide monitor to the Health Board for checking. And the blood pressure machine was new as the team had not had training on this. And had not started using it. The pharmacy stored medication waiting collection on shelves in a rear area of the pharmacy. The team attached the prescriptions to the bags. The computer screens were out of view of the public. And locked when not in use. The team used cordless phones for private conversations.

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.