General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 1 Victoria Road, BRORA, Sutherland, KW9 6QN

Pharmacy reference: 1042970

Type of pharmacy: Community

Date of inspection: 04/09/2019

Pharmacy context

The pharmacy is on a main road in the centre of Brora. It dispenses NHS prescriptions and provides a range of extra services. The pharmacy collects prescriptions from local surgeries. And it supplies medicines in multi-compartmental compliance packs when people need extra help. Consultation facilities are available. And people can 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 work to professional standards. They provide safe services and look after people’s welfare. The pharmacy keeps records of mistakes when they happen. And they make improvements to keep services safe. The pharmacy keeps the records it needs to by law. And the team members understand their role in protecting vulnerable people. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means they listen to people and put things right when they can.

Inspector's evidence

The pharmacy displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy used standard operating procedures (SOPs) to define the pharmacy processes and procedures. And the team members were in the process of reading a new set of SOPs. The company was about to release new dispensing SOPs to replace those that had expired earlier in the year. And this ensured that team members followed current practices and provided safe and effective services. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The team members recorded their own errors using an electronic system. And they were prompted to provide a reason for making the error. The pharmacist carried out a monthly near-miss review. And recorded and discussed the findings with the team members to identify ways of managing risks. Sample reviews showed the following actions;
1. Highlighting look-alike and sound-alike medication such as pregabalin/gabapentin.
2. Contacting GPs to write Clenil and not beclomethasone. And this was due to dispensing the nasal spray and not the inhaler on more than one occasion.
3. Separating colecalciferol tablets/capsules due to mix-ups.
4. Discussing the increase in the number of near-misses. And agreeing to support team members due to changes in working arrangements.

The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about an error involving quetiapine 200mg and 25mg. And the pharmacist had arranged for the medication to be separated and a caution label to be attached to the shelf-edges. A note had also been added to the prescription that was registered with the chronic medication service (CMS). The superintendent pharmacist produced and issued a newsletter that provided patient safety information. For example, a recent issue had highlighted the risk of selection errors associated with amlodipine/atorvastatin medication. And described an incident when a dispenser referred a concern about a prescription for Madopar capsules that had been previously discontinued. The article highlighted the value of dispensers checking prescriptions before they were handed to the pharmacist for a final check. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used a notice to inform people about the complaints process and who to contact should they wish to complain or provide feedback. The pharmacy received mostly positive comments. And had been able to satisfy requests for certain brands if appropriate.

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 had public liability and professional indemnity insurance in place and this was valid until 30 April 2020. 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 team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists had been accredited to use patient group directions to improve access to medicines and advice. And a sample trimethoprim patient group direction was seen to be valid until October 2020.

The pharmacy displayed a 'fair data processing notice' which provided people with information about its data protection arrangements. And the pharmacist trained team members during induction to comply with data protection arrangements. The team members knew how to safeguard personal information. And disposed of confidential information in designated bags which were uplifted for off-site shredding.

The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. The pharmacy trained the pharmacy team to comply with safeguarding arrangements. And provided contact details so that team members knew who to contact if they had a concern about a child or a vulnerable adult. The pharmacy team knew most of their customers. And knew when to refer to the pharmacist. For example, they monitored the supply of multi-compartmental compliance packs. And informed the surgery and carers when people failed to collect their medication on time, so they could provide extra support if needed. A trainee dispenser knew when to refer concerns to the pharmacist. For example, when people tried to buy excessive quantities of medicines liable to abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had not experienced any significant growth over the past year. And the work-load had remained mostly the same. The company used performance targets. For example, registering people with the chronic medication service (CMS). The team members explained that the targets were designed to benefit people. And they did not feel undue pressure to register people with the services they provided.

The team members had worked at the pharmacy for many years and lived within 1 mile of the pharmacy. And this had been beneficial during bad weather conditions. The team members were experienced and knowledgeable in their roles. And they kept their training certificates on-site. The following team members were in post; one full-time pharmacist, one full-time dispenser, one part-time trainee dispenser, two part-time medicines counter assistants and one delivery driver. The pharmacy team members submitted holiday requests in advance. And this ensured that minimum levels were maintained. An area relief dispenser was based in the pharmacy two days per week. And could provide cover when necessary.

The pharmacist carried out annual performance reviews to identify areas for development. For example, the dispenser had expressed an interest in the NVQ pharmacy services level 3 course. The pharmacy provided ongoing training so that team members were competent in their roles. For example, the medicines counter assistant had completed several product-based e-learning modules, and had covered, anti-histamines, Solpadeine and Tena products. The pharmacist kept the team members up-to-date with changes. And had recently informed them about the falsified medicines directive (FMD) and the re-classification of pregabalin and gabapentin products. The pharmacy team members had been trained to provide advice and sell cannabidiol (CBD) oil. And they made sure that people knew it was classified as a food product. And did not contain any psychoactive substances.

A pharmacist new to the company was undergoing induction. And was being supported to take up a new post in another branch. The regular pharmacist had completed a two-day palliative care training course. And had been able to provide support and signposting to people, their carers and family members when needed. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, the dispenser had separated the nasal sprays and inhaler devices to manage selection risks and to avoid near-misses and incidents.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean. And provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided a range of healthcare information leaflets for self-selection. The team members dispensed walk-in prescriptions near to the waiting area. And the pharmacist supervised the medicines counter from the checking bench. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room which was professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information in the window. And it lets people know about its services and when they are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy dispenses multi-compartmental compliance packs. And supplies extra information to these people to support them to take their medicines. The pharmacy sources, stores and manages its medicines appropriately. And updates the pharmacy team about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had step-free access at the entrance to the pharmacy. And provided unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in its window. And displayed patient information leaflets in the waiting area and in the consultation room. The pharmacy kept good levels of fast-moving stock. And this managed the risk of running out of regular medicines during bad weather and traffic disruptions. The pharmacist had a good working relationship with neighbouring pharmacies and shared medications when needed. The pharmacy team dispensed, and managed prescriptions registered with the chronic medication service (CMS). And this accounted for around 20 to 25% of its workload. The team members kept records of dispensing and supply. And they intervened when people failed to collect their medication on time. The team members spoke to people and identified issues. And referred people to the pharmacist. For example, they identified someone who had stopped taking some of their medication. And had stock-piled around six months' worth of it at home. The pharmacist had arranged a GP referral. And was providing support each time the person arrived at the pharmacy to ensure compliance.

The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 18 people. The team members used a separate bench for dispensing. And they used trackers to manage the work-load to make sure that medication was dispensed and supplied on time. A regular dispenser carried out checks at the start of the week. And ordered new prescriptions when needed. The team members removed and isolated packs when they were notified about prescription changes. And a record was made in the patient's medication record. The pharmacy supplied patient information leaflets and provided descriptions of medicines.

The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy used a controlled drug cabinet. And kept expired and returned medication separate to avoid dispensing incidents. The team members carried out regular stock management activities. And highlighted short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius.

The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers

that the health board collected. The pharmacy team members acted on drug alerts and recalls. For example, they had actioned an alert in August 2019 and shared new evidence about the risks associated with HRT products with the pharmacy team. The team members knew about the valproate pregnancy protection programme. And they knew to provide safety leaflets and cards. The pharmacist monitored prescriptions for valproate. And confirmed that people received safety information from their GP. The pharmacist added notes to people's PMR. And kept a record in a folder beside the warning leaflets and cards. The pharmacy had not introduced the Falsified Medicines Directive (FMD). And the team members were unable to confirm when it was due to be implemented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard. And it used crown-stamped measures for measuring liquids. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And arranged computer screens so they were only visible to pharmacy team members. The pharmacy used portable phones. And the pharmacy team took calls in private when necessary.

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.