General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 8 The Square, Fallin, STIRLING, Stirlingshire, FK7 7JE

Pharmacy reference: 1090616

Type of pharmacy: Community

Date of inspection: 15/04/2019

Pharmacy context

The pharmacy is in the village of Fallin, which lies 3 miles east of Stirling. It dispenses NHS prescriptions and offers a range of additional services. The pharmacy provides a prescription collection and delivery service. And supplies medicines in multi-compartment medicine devices when people need extra support. 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	1.8	Good practice	The pharmacy team are proactive and take steps to better understand vulnerable groups. This improves 2 way communication. And the pharmacy team are able to support people to ask for help when they need it.
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 team members discuss the need for new safety measures. And there is ongoing service improvement. 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 new pharmacist was providing cover at the time of the inspection. The responsible pharmacist notice was visible from the waiting area. And displayed the name and registration number of the pharmacist on duty. The pharmacy team signed to confirm they followed standard operating procedures. The procedures defined the pharmacy processes and staff responsibilities.

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

The pharmacy team discussed the near-misses once a month. And agreed and documented actions to manage the risks. The pharmacist sent details of the near-miss review to the superintendent pharmacist. And all of the branch records were reviewed with trends highlighted in a quarterly newsletter.

The pharmacy team provided examples of change to manage common dispensing errors. For example, in January 2019 agreeing to mark critical information when carrying out accuracy checks, such as strength and quantity. In February 2019, the pharmacy team agreed to highlight the shelf that was used to store pregabalin/gabapentin products due to forthcoming changes in legislation and subsequent prescription requirements.

The pharmacy team were proactive at managing the risks associated with selection errors. And had highlighted Betmiga 25/50mg products.

The superintendent’s issued a newsletter on a regular basis. And in January 2019 the newsletter had highlighted patterns and trends across the company. For example, mix-ups with co-beneldopa and co-careldopa. Improvement action had been provided, and teams were instructed to re-start the dispensing process when distracted by another task.

The pharmacist managed the incident reporting process. The pharmacy team knew when incidents had happened and what the cause had been. The superintendent's newsletter had highlighted four incidents to allow the pharmacy teams to reflect on their current practice. For example, when multi-compartment medicine devices had been mixed-up and put into the wrong dispensing bags.

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.

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 on a regular basis.

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 new pharmacist had moved from another health board area. And was in the process of reading the Forth Valley patient group directions so that she was accredited to provide additional services and improve access to a range of medicines and advice. This included providing access to steroids and antibiotics for people suffering from chronic obstructive pulmonary disease.

The pharmacy team completed data protection training during induction. And were expected to read and sign a patient confidentiality and consent standard operating procedure. And knew to comply with data protection requirements. The pharmacy displayed a data processing notice in the waiting room. And this informed people that their personal information was always safeguarded. The staff disposed of confidential information in designated bags. And a collection service uplifted the bags for off-site shredding. 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 used individual passwords to restrict access to patient medication records. And took calls in private using a portable phone when necessary.

The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the pharmacy had registered the pharmacists with the scheme. The pharmacy team had read and signed the safeguarding procedure. And knew to raise concerns when they recognised the signs and symptoms of abuse and neglect. Staff were aware of vulnerable groups. And key contact details were available should a referral be necessary. The pharmacy team provided several examples of referrals, such as people presenting for methadone doses who were intoxicated.

Public liability and professional indemnity insurance were in place. And was valid until 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. They identify and discuss their learning needs at regular review meetings.

This ensures they 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. They can speak up and suggest service improvements. They share ideas and learnings to keep services safe.

Inspector's evidence

A new pharmacist had recently taken up post. And double pharmacist cover had been provided during the induction period. An area manager was available as was the superintendent pharmacist if needed.

The pharmacy work-load had increased over the past year. But, the pharmacist provided assurance that the staffing levels were adequate.

The pharmacy team were long-serving and experienced. And staff qualifications were kept on-site so that evidence of accreditation was available. The following staff were in post; 1 full-time responsible pharmacist and 3 x full-time dispensers.

The pharmacy team provide Saturday cover, and this ensured service continuity. The pharmacy allowed 1 member of staff to take annual leave at the one time. And part-time staff increased their hours to ensure there was enough cover to complete tasks. The pharmacist could contact a nearby branch or head office to arrange cover in the event of unexpected leave.

The company did not set numerical targets. And knew only to register people with services that would be of benefit. The pharmacy team did not feel under pressure in their day-to-day work.

The pharmacy used quarterly performance reviews to develop staff. For example, a member of staff had asked to attend First Aid training, and this had been agreed.

The pharmacy team members raised concerns and provided suggestions for improvement. An experienced dispenser was committed to learning about ways to support vulnerable individuals. And had discussed the need for training to support her and colleagues to do so. The dispenser had contacted the community alcohol and drug service and had arranged training. This had made the pharmacy team more knowledgeable and had improved communication with vulnerable people.

The pharmacy team had been recognised through a pharmacy sector award for the support they

provided to their community.

A dispenser provided an example of an initiative. And after speaking to a women's aid representative had obtained supplies of lip-balm with the telephone number of women's aid printed beside the product barcode. And these were issued to vulnerable women who were thought to be at risk, but not ready to ask for help.

The company provided e-learning, and staff were allocated time in the work-place to complete it. The company did not prioritise the training modules and allowed staff to choose topics, for example a member staff had completed a module about skin conditions the previous week.

The pharmacy team attended the company's annual conference. And guest speakers provided training in relevant subjects. For example, the pharmacy team had learned about 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 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 well-kept waiting area presented a professional image to the public.

A consultation room was available and kept professional in appearance.

The pharmacy had allocated benches for the different dispensing tasks. The pharmacy team dispensed walk-in prescriptions near to the waiting area. And dispensed multi-compartment medicine devices in a rear room.

The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed.

A security alarm and shutters 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 provides a range of services to the surrounding area. It provides service and health information leaflets for self-selection. And displays opening times and service information in the window.

The pharmacy supports housebound and vulnerable people. It dispenses multi-compartment medicine devices. And provides a delivery service for people who need extra help.

The pharmacy manages its services well. 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

People with mobility difficulties could access the pharmacy via a level surface.

The pharmacy provided seating in the waiting area. And although a range of patient information leaflets were available, not all of them were available for self-selection.

The pharmacy collected prescriptions from both the local surgery and further afield. And it provided a delivery service to housebound and vulnerable people. The delivery driver made sure that people signed for controlled drug prescriptions to confirm receipt.

The pharmacy provided enhanced access to medicines and advice. And had been contracted to provide emergency access to steroids and antibiotics for people suffering from chronic obstructive pulmonary disease.

The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process.

The pharmacy identified people that would be suitable for the chronic medication service. And the pharmacy team used a questionnaire to identify if people needed support to take their medicines.

The pharmacist intervened when clinically appropriate. For example, contacting a prescriber when someone presented with a new prescription for simvastatin when they were already taking amlodipine. And advising a reduction in the simvastatin dose due to its effects.

The pharmacy provided multi-compartment medicine devices for people who needed extra support. And one of the dispensers managed the service with the other dispensers taking it in turn to dispense the devices. The pharmacy used trackers to manage the work-load, and to avoid people going without

medication.

The pharmacy team recorded changes on the patient medication record sheets. And confirmed that the electronic patient medication record was up to date. The pharmacy team supplied patient information leaflets and descriptions of medicines. And highlighted the days of the week when people were getting mixed-up.

The pharmacy team dispensed methadone doses once a week. And checks were carried out and doses stored in the controlled drugs cabinet until they were needed. The pharmacy team presented the prescription and the methadone dose for another final accuracy check at the time of supply.

The pharmacy team kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers.

The pharmacy kept controlled drugs in a cabinet for extra security and to comply with safe custody requirements. The cabinet was organised to avoid selection errors. For example, the pharmacy used baskets to store methadone.

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 2 and 8 degrees. The pharmacy used plastic bags for refrigerated items. And this allowed additional checks to be easily completed by the pharmacy team and patients alike.

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. And recorded the outcome, and the date they checked for affected stock. For example, they had checked stocks of chloramphenicol in February 2019 with none found.

The pharmacist had briefed the pharmacy team about the use of valproate in women. And the pharmacy team knew about the pregnancy protection scheme and where to find safety leaflets and cards. The pharmacist had carried out an initial audit with no people affected. And in September 2018, a new prescription was presented by a female of 53 and counselling and advice was provided.

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

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 solution was also available. The pharmacy sink was clean and suitable for dispensing purposes.

Reference sources were available. For example, the current copy of the BNF and BNF for children were in use. A consultation room was available. 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.