General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rightdose Pharmacy, 6 Eyre Place, EDINBURGH, Midlothian, EH3 5EP

Pharmacy reference: 1091880

Type of pharmacy: Community

Date of inspection: 04/06/2019

Pharmacy context

This is a community pharmacy close to a city centre. It is in an area with some residential property and offices and close to a GP practice. People of all age use the pharmacy, including students and seasonal visitors. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs.

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	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 follow processes for all services to ensure that they are safe. They record mistakes to learn from them. And they make changes to avoid the same mistake happening again. The pharmacy keeps all the records that it needs to by law and keeps people's information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which team members followed for all activities/tasks. They had all read and signed relevant SOPs. The pharmacy reviewed SOPs every two years and they were signed off by the pharmacy superintendent. Staff roles and responsibilities were recorded on individual SOPs.

Dispensing, a high risk-activity, was managed in a logical manner using different coloured baskets to separate patients' medicines and differentiate between different prescription types. Team members used different areas of the dispensary for dispensing different types of prescription. Team members signed dispensing labels to provide an audit trail of who had dispensed and checked medicines. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Pharmacy team members recorded some near miss errors and discussed these but did not undertake formal reviews to identify trends. They described strategies that had been put in place to minimise repeat incidents such as labelling shelves to highlight high-risk items and separating items on the shelves e.g. atenolol and amitriptyline. They had undertaken an extensive review of the management of multi-compartmental medicine devices following a recent incident. And they had introduced some additional processes to improve accuracy. These included medicines being checked before being placed into the devices and retaining copies of patient information leaflets until prescriptions were completed. Team members used these leaflets to confirm tablet descriptions if there were any queries. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

The pharmacy had a complaints procedure in place. Team members described responding to people's feedback and body language when accessing pharmacy services. They had moved pregnancy tests to a more discreet area of the premises following feedback. They had developed a discreet way of notifying the pharmacist when there was a request for emergency contraception. The pharmacy kept specific brands of description medicines for several patients and these were kept on designated shelves. Indemnity insurance certificate was in place, expiring August 2019.

The following records were maintained in compliance with relevant legislation: Responsible Pharmacist notice displayed; Responsible pharmacist log; Private prescription records including records of emergency supplies and veterinary prescriptions; Unlicensed specials records; Controlled drugs registers, with running balances maintained and regularly audited; Controlled drug (CD) destruction register for patient returned medicines. The electronic patient medication records were backed up each night to ensure no data was lost.

Pharmacy team members were aware of the need for confidentiality and they had read and signed an SOP. They segregated confidential waste for shredding which was done three times each day. And they

ensured no person identifiable information was visible to the public. Team members obliterated people's names on any labels destroyed in the pharmacy. The delivery drivers collected prescriptions from surgeries in folders to avoid patient details being seen. They carried identification to ensure that prescriptions for the correct pharmacy were provided from GP practices.

Team members had read and signed an SOP on safeguarding. The drivers and pharmacist were PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members. They have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. Team members can share information and raise concerns to keep the pharmacy safe. They make suggestions to improve services and discuss incidents. They learn from them to avoid the same thing happening again.

Inspector's evidence

Staff numbers during the inspection were: One full-time pharmacist manager, and various locum pharmacists covered her day off;
two full-time dispensers, not medicines counter trained.; One part-time medicines counter assistant, three days per week; two drivers shared with another branch. One driver collected prescriptions from GP practices, and the other delivered medicines to patients.

The pharmacy had staffing challenges over the past year when an experienced medicines counter assistant had left and there was difficulty recruiting. The team was now stable and team members undertaking training. The pharmacist was aware that the dispensers could not work on the medicines counter until they were registered on an appropriate training course. This was planned, as they had to work on the medicines counter when the medicines counter assistant was not working.

The medicines counter assistant had recently completed her training and there were plans for her to commence dispensary training. She was able to work additional hours to cover some absence.
The team was able to manage the workload.

The pharmacy provided protected learning time for team members undertaking accredited training. A dispenser was working on the NVQ 3 qualification and was ahead of where she would be expected to be. She explained that she undertook some work at home in her own time as well as at work. The recently qualified medicines counter assistant described protected time at work to complete her course, and support and assistance from colleagues ‘on the job’. The pharmacist supervised activity on the medicines counter as her checking area overlooked it.

Team members described other ongoing training and development, such as material left from drug company representatives. They also had access to ‘Counter Excellence’ modules and they could read any of these that interested them, or when they felt there was need for the learning. The pharmacy had recently given all team members time to read new SOPs.

Team members went about their tasks in a systematic and professional manner. They exhibited a friendly manner with people. They asked appropriate questions when recommending and selling over-the-counter medicines and were aware of items subject to abuse. The medicines counter assistant was empowered and competent to liaise with company representatives and order stock. This was observed during the inspection.

The pharmacy team members described an open and honest environment where they felt comfortable owning up to their own mistakes. They discussed these openly to reduce the risk of similar incidents.

They understood the importance of reporting mistakes. A recent incident had been fully discussed, and the company healthcare officer had been involved and supportive. The team had met to discuss ways of improving the process following this incident. All team members took part in devising instructions covering improvements, and these were fixed to the wall for all to refer to undertake this activity.

Team members knew how to contact a company director, the 'healthcare officer' who visited the pharmacy approximately monthly. They could raise concerns with him and ask for support. They did not have much contact with the pharmacy superintendent, but the healthcare officer fulfilled this role for the pharmacy.
Targets were not set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. Pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably sized premises, with a large dispensary. The dispensary was naturally divided into three areas that were well used for different types of dispensing and storage.

There were sinks in the dispensary, staff room, consultation room and toilets. These had hot and cold running water, soap, and clean hand towels. The pharmacy had a public toilet which could be used by people accessing pharmacy services. The premises were observed to be clean, hygienic and well maintained.

People were not able to see activities being undertaken in the dispensary. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. It had another room furnished with a clinical bench, which could be used for other services. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. It considers introducing services that people might want. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with high risk medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy was accessed by a ramp at the entrance and assistance given with the door if required. The pharmacy listed its services and had leaflets available on various topics. It had a low counter to assist wheelchair users. Team members provided large print labels on dispensed medicines for some people with impaired vision. They occasionally used Google translate to communicate with people who did not speak English, particularly during the summer when there were a lot of visitors in the city.

The pharmacy provided flu vaccination during the season. The pharmacy team had identified a need for travel services, so training was planned over coming months to establish a travel clinic. In the meantime, they signposted people to this service in a nearby pharmacy. The pharmacy was looking to identify other services that would be beneficial in the area. During the inspection, a physiotherapist looked at the additional consultation/treatment room with a view to establishing a triage physiotherapy service in the pharmacy.

Dispensing work flow was smooth and logical with designated areas for dispensing and checking. The pharmacy team used coloured baskets to separate patients' medicines, and labels to identify high-risk items, medicines requiring stored in the fridge or controlled drug (CD) cabinet and highlight when pharmacist consultation was required. Each morning, one dispenser assembled multi-compartmental medicines packs while the other labelled prescriptions collected from the GP practices, and dispensed prescriptions for people waiting. Both dispensers labelled and dispensed prescriptions in afternoons. Team members described this system as efficient, and by the end of each day all prescriptions received that day had been assembled. They signed dispensing labels to provide an audit trail of who had dispensed and checked medicines. And they usually assembled owings later the same day or the following morning.

The pharmacy provided a delivery service, and the driver obtained signatures from people receiving controlled drugs. He delivered items requiring cold storage and controlled drugs first. There were not usually many of these. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Both dispensers were involved in this activity, undertaking it on alternate weeks. They always assembled packs at least a week before they were required which gave adequate time to undertake this activity without undue pressure. They also had time to contact prescribers with any queries and obtain replacement prescriptions if necessary. Completed trays were labelled with patient details and date of supply. The backing sheets also had the correct start date on them. A dispenser explained that following hospital admissions when trays not been supplied, the dates were incorrect. They always changed them following hospital discharge to ensure that they had the correct date of supply/start. Patient information leaflets (PILs) were supplied with the first pack of each prescription. Copies were retained to enable team members to check tablet descriptions if there were any queries.

A dispenser poured methadone instalments weekly and these were checked by a pharmacist before being stored in a controlled drug (CD) cabinet. The pharmacist sometimes took these out of the cabinet in the morning for that day and stored them under her supervision. There were a variety of other medicines supplied by instalment and the dispenser assembled these weekly on a different day. A pharmacist checked these at the time of dispensing. Labels on medicines supplied by instalment had the date of supply on them.

The pharmacist undertook clinical checks and provided information to people as required. She provided additional information to people taking high risk medicines including valproate, methotrexate, lithium, and warfarin. Written information and record books were provided if required. The pharmacy had implemented the valproate pregnancy prevention programme by checking if it applied to any patients in this pharmacy. It did not, but all team members were aware of it and could advise appropriately if necessary. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and gave written and verbal information to people supplied with these medicines over-the-counter or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. They explained that dispensing labels now had this advice for relevant medicines.
The pharmacy followed the service specifications for NHS services and had patient group directions (PGDs) in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment.

Team members were empowered to deliver the minor ailments service (eMAS) within their competence. The pharmacist worked immediately behind the medicines counter so could overhear requests and consultations. Team members asked for advice appropriately, and the pharmacist intervened if necessary.

The pharmacy obtained medicines from licensed suppliers such as Alliance, AAH, Numark, Phoenix, and Ethigen. The pharmacy was not yet compliant with the requirements of the falsified medicines directive (FMD). It had the hardware and software in place, but team members had not yet had training. A dispenser described spending time trying to work out process from a website. Records of date checking were observed, and items inspected were found to be in date. The pharmacy stored medicines in original packaging on shelves/in cupboards. It kept particular brands required by some people on separate shelves, and this was also recorded on people's medication records. Items requiring cold storage were stored in two fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits.

The pharmacy protected pharmacy (P) medicines from self-selection and followed the sale of medicines protocol when selling these. It had information on the wall about consultation principles to assist team members.

Team members actioned MHRA recalls and alerts on receipt and kept records. They contacted relevant people following patient level recalls. Items received damaged or faulty were returned to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. The pharmacy had a carbon monoxide monitor which was maintained by the health board. It was kept in the consultation room where it was used with people accessing the smoking cessation service. The pharmacy had a range of Crown stamped measures which were used for measuring methadone solution. And it had ISO marked measures which it used for measuring water.

Clean tablet and capsule counters were also kept in the dispensary, and separate marked ones were used for cytotoxic tablets. The pharmacy stored paper records in the dispensary inaccessible to the public.

Pharmacy team members did not leave computers unattended and they used passwords. They ensured that computer screens were not visible to the public, and phone conversations could not be overheard.

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.