General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, Fordhill, Broadford, ISLE OF SKYE, IV49 9AB

Pharmacy reference: 1094081

Type of pharmacy: Community

Date of inspection: 26/04/2019

Pharmacy context

The pharmacy is in the village of Broadford on the Isle of Skye. It is connected to Scotland's North West coast by bridge. And lies 88 miles west of Inverness. A sister branch is in the Kyle of Lochalsh is a 15-minute drive away. The pharmacy dispenses NHS prescriptions and offers a range of additional services. It orders and dispenses prescriptions for people on repeat medication. 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	2.2	Good practice	A quarterly performance review identified development needs. The pharmacy provided a range of training opportunities. This included on-site and off-site events. And the pharmacy team completed training on a regular basis.
		2.4	Good practice	The pharmacy had developed a learning culture. And the pharmacy team were proactive at identifying learning opportunities. This had produced a team who were supportive of each other. And this had resulted in safe and effective services.
		2.5	Good practice	The pharmacy encourages and supports the pharmacy team to raise concerns and make suggestions for improvement. And there is evidence of significant service improvement in light of suggestions.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy had registered a significant number of people with the chronic medication service. This meant they could monitor supplies. And provide support so that people achieved the most from their medicines.
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 discusses 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

The pharmacist displayed the responsible pharmacist notice. And people could identify who was in charge.

The pharmacy used electronic standard operating procedures to define the pharmacy processes and staff responsibilities. The pharmacy team had signed a separate document to confirm they had read the standard operating procedures. But, this was being kept in the same folder as previous superseded standard operating procedures.

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 pharmacy team recorded the near-misses. And identified the contributing factors. This meant that improvement action could be identified and discussed.

Sample near-miss reports were selected for February and March 2019. The pharmacy team had identified labelling errors as a common occurrence, followed by the wrong strength and incorrect quantities. And had agreed to read hand written prescriptions more carefully. The pharmacy team had identified increases in nurse prescribing due to GP shortages. And the pharmacist had contacted NHS Highland to discuss the need for bar-coded prescriptions to minimise errors.

The pharmacy team were proactive. And segregated products with similar sounding names and similar packaging.

The pharmacy technician knew about the superintendent's quarterly newsletter. And read about near-misses and incidents across the company. This provided the opportunity for the pharmacy team to reflect and make changes to manage risks. The pharmacy technician could recall reading about changes to pregabalin and gabapentin. And their new controlled drug status.

The pharmacist managed the incident reporting process. The pharmacy team knew when incidents happened and what the cause had been. For example, the pharmacy team had attached shelf edge caution labels to the lamotrigine shelf due to a mix up with Tegretol tablets. This aimed to manage the

risk of a recurrence in the future.

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 team acted on feedback. And tried to meet people's needs when they could. For example, they provided specific brands when asked. And were providing co-codamol tablets to someone who preferred the foil packaging they were presented in.

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 trimethoprim patient group direction was valid until October 2020.

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 in designated bags. And a collection service removed the waste 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 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 team provided an example when they had concerns about a young vulnerable female. And were concerned that people were taking advantage of her. The concern was referred to the medical centre. And the female was now living in sheltered accommodation.

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. 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. The team are good at taking ownership of tasks. And make service improvements to keep services safe and effective.

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 part-time team member leaving. And confirmed that a replacement was needed. The pharmacist recruited a new full-time member of staff to provide flexibility and cover at the Broadford and Kyle of Lochalsh branches.

The pharmacy kept staff qualifications on-site so that evidence of accreditation was available. And the following staff were in post: two responsible pharmacists (one whole time equivalent); one full-time pharmacy technician; one full-time medicines counter assistant; and one x 12.5 hours dispenser.

The pharmacy allowed one member of staff to take annual leave at the one time. And a locum pharmacy technician that worked in the area provided cover when needed. A sister branch was located approximately 9 miles away. And staff could be called on to provide cover.

The pharmacy supported staff that were in training. And the pharmacist had agreed protected training time for the trainee dispenser. This was carried out in the consultation room when it was free. The pharmacy provided shadowing opportunities for trainee doctors and nurses that were employed at the nearby medical practice. 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. The trainee dispenser provided access to her electronic learning record. And had completed several modules including eye and stomach conditions. The pharmacy technician produced her training record. And multiple entries had been made including attendance at NHS Education for Scotland events at the local hospital. For example, a session about non-steroidal anti-inflammatory drugs.

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. The pharmacy technician was empowered and had been responsible for service improvements which were introduced in the other branches. For example, developing individual records for people to sign when they collected multi-compartment medicine devices. And aimed to safeguard confidentiality and monitor collections.

The pharmacy technician was investigating the use of the patient medication record to manage serial prescriptions. This was due to the increasing number of people being registered with the chronic medication service.

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 mental health and dental conditions.

The pharmacy team members raised concerns and provided suggestions for improvement. And a WhatsApp group was used to increase communication across the region. For example, when the pharmacy team were re-organising the retrieval system. They contacted the other branches for ideas. And a new system was introduced.

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 a rear 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 CCTV was 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 manages its services well. And it has taken over the ordering and dispensing of prescriptions for people who are on regular medication. This means that people do not always have to go to their doctor for a new prescription. And can go directly to the pharmacy for further supplies of their medication. The pharmacy informs the pharmacy team about high-risk medicines. This means they 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 level access and a power assisted door was available. People with mobility difficulties could access the pharmacy without restriction. The pharmacy displayed its opening hours at the front of the pharmacy. And service information was available. It also displayed the opening hours of the nearby medical centre.

The pharmacy had been registering people with the chronic medication service. And serial prescriptions accounted for a significant proportion of the dispensing work-load. A new practice pharmacist had taken up post at the nearby surgery. And the number of serial prescriptions continued to grow. The pharmacy team managed the chronic medication service, attaching forms to each serial prescription. And recording the next due date after a supply was made. The pharmacy team monitored prescriptions and intervened when people did not collect them on their due date.

The pharmacist provided examples of interventions. For example, contacting the GP when a prescription for Buccastem was issued. This was due to the product license stating the product should only be used in people over the age of 18.

The pharmacist provided support to the NHS Highland care at home team. For example, ensuring that chloramphenicol eye ointment was discarded after 28 days of opening. The pharmacy team attached labels to prescription bags to communicate key messages. For example, using a pharmacist label to highlight that a controlled drug needed to be added.

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 pharmacy provided multi-compartment medicine devices for people who needed extra support. The pharmacy team used trackers to manage the work-load. And 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 well-managed and this ensured that the right medicine was supplied at the right time.

The pharmacy kept a business continuity plan up to date. And this could be used in the case of an emergency. A sister branch in Kyle of Lochalsh was approximately nine miles away. And stock was shared when necessary.

The pharmacy kept controlled drugs in a well-organised cabinet to avoid selection errors.

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 chloramphenicol in April 2019 with none found. And the outcome and date of check was recorded, and records retained.

The pharmacist had briefed the pharmacy team about the use of valproate for people who may become pregnant. And they knew about the pregnancy protection scheme and where to find safety leaflets and cards. The pharmacy had carried out a review of their patient medication records. And confirmed they had no-one was affected.

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 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.