General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 32A Main Street, Cowie, STIRLING, Stirlingshire, FK7 7BL

Pharmacy reference: 1097366

Type of pharmacy: Community

Date of inspection: 25/01/2023

Pharmacy context

This is a community pharmacy in Cowie. It dispenses NHS and private prescriptions and provides a substance misuse service. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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 uses written procedures to help team members manage risks and keep services safe. They suitably protect people's private information and keep the records they need to by law. And they recognise and appropriately respond to safeguarding concerns about vulnerable people. But team members do not consistently complete records to help them manage risk. This means the pharmacy may miss opportunities to learn and improve.

Inspector's evidence

The pharmacy had control measures to manage the risks and help prevent the spread of infections. This included a plastic screen and hand sanitizer at the medicines counter for visitors and team members to use. The pharmacy used 'standard operating procedures' (SOPs) which defined the pharmacy's working practices. The company issued new SOPs via an online operating system. And the pharmacist checked the system on a regular basis instructing pharmacy team members to read any new SOPs that the company had released. A review of some SOPs showed the 'responsible pharmacist' and 'controlled drug' procedures were up to date. And team members had signed a paper record to confirm they had read and understood them. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. Team members knew to reflect on and to record near misses and to identify the reasons for them. But records showed they had last documented a near miss at the beginning of October 2022. And this meant the pharmacy might be missing dispensing risks and opportunities to learn and improve. Team members had made some safety improvements such as using shelf edge caution labels to highlight 'look alike and sound alike' (LASA) items. For example, they had highlighted the diferences between ropinirole and risperidone and candesartan 8mg and 16mg.

The pharmacy provided information about its complaints process on a notice that was visible from the waiting area. And team members listened to verbal feedback about services for future planning. The pharmacy was in a village and people had provided positive feedback about the pharmacy's new vaccination service. This was due to some people no longer having to use public transport to travel to the nearest town to receive flu and covid vaccinations. Team members knew to record mistakes that were identified after a person received their medicine, on an electronic template which they sent to the superintendent to review. The template included a section to record information about the root cause and any necessary safety improvements. A new area manager visited the pharmacy to support team members. And they had discussed plans to introduce mock inspections to provide assurance the pharmacy was operating safely.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 17 January 2024. The pharmacist displayed an RP notice which was visible from the waiting area. And they kept an electronic RP record to show when their duties began and ended. Team members maintained 'controlled drug'(CD) registers and kept them up to date. They checked the balance of CDs at least once a month and they also checked the balance each time they made a supply. People returned CDs they no longer needed for safe disposal. And team members used an electronic CD destruction register to record items. The pharmacist logged on to the system using their own unique logon credentials. And they annotated records to evidence that items had been safely disposed of. Team members filed prescriptions so they

could easily retrieve them if needed. The pharmacy kept records of private prescription supplies. And records complied with legal requirements. They were clear and legible and the associated paper prescriptions were kept in a folder in date order. Team members kept certificates of conformity for unlicensed medicines, and these complied with Medicines & Healthcare Regulatory Agency (MHRA) requirements.

Team members understood data protection requirements and how to protect people's privacy. And a notice that was visible from the waiting area provided information about the pharmacy's data protection arrangements. Team members used a designated container to dispose of confidential waste. And the company collected the waste for off-site destruction at its head office. Team members understood their obligations to manage safeguarding concerns. They knew to speak to the pharmacist whenever they had cause for concern about a vulnerable person. The pharmacist and the dispensers provided examples of when they had acted to safeguard individuals. And following a recent incident, the RP had contacted the SI's office to update them. The information had been cascaded which helped the other pharmacy teams in the other branches reflect and review their own procedures.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together to suitably manage the workload. The pharmacy supports team members to develop in their roles. And they continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had increased over the past year. And team members had been able to manage the extra workload without the need for more staff. A regular pharmacist had been in post for around three years. And a second newly qualified pharmacist supported so the regular pharmacist could undergo 'pharmacist independent prescriber' (PIP) training. The company employed relief dispensers and pharmacists and the pharmacy did not rely on locums. For example, a new trainee relief dispenser and a pharmacist were providing extra support at the time of the inspection. The pharmacy team comprised of one full-time pharmacist with regular second pharmacist cover, one full-time trainee dispenser, one part-time long-serving dispenser, one part-time long-serving medicines counter assistant, one trainee pharmacist, one part-time pre-registration pharmacy technician and one full-time delivery driver.

The pharmacist supported team members to learn and develop. And provided them with protected learning time in the workplace when possible. The company arranged for relief pharmacists and dispensers to provide double cover to support trainees when possible. Team members maintained their knowledge of the 'standard operating procedures' (SOPs) that were relevant to their role. And they completed bite-sized training that the company arranged such as refreshing their knowledge of 'over the counter' (OTC) treatments for coughs and colds. The health board delivered training to support pharmacy teams provide services. And all team members had completed training to help deliver the smoking cessation service. The health board had delivered on-site training in the pharmacy. And most of the team members had learned to operate a new system that was used to communicate service information. This included the reporting of missed doses of some medications so that alternative arrangements could be arranged in a timely manner. Team members were aware of whistleblowing procedures. And they felt empowered and able to speak up if they had a concern.

Team members learned together, and they read and discussed the 'superintendent pharmacist's' (SIs) newsletter. This included information about safety incidents, case studies and learnings from near miss errors. The newly qualified pharmacist who was providing relief cover, had been prioritising learnings and had a current focus on incidents involving 'controlled drugs' (CDs). They had also read the 'serious shortage protocols' (SSPs) for HRT treatments and antibiotics to treat infections. Team members had learned about the company's proposed changes to multi-compartment compliance pack dispensing procedures. And they had prepared to implement the changes and provide feedback about the outcomes. A trainee pharmacist was responsible for managing distinct areas of work so they could gain experience. This included the dispensing of some medicines that required to be consumed under supervision on the premises. A pre-registration pharmacy technician worked at the pharmacy two days per week. They also worked in primary care in GP practices. This had benefited the pharmacy team with prescription queries when people were discharged from hospital.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. It has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was in a purpose-built premises. A sound-proofed consultation room with hot and cold running water was available for use. And it provided a clinical environment for the administration of vaccinations and to carry out various checks such as blood pressure monitoring. A designated sharps bin was available to dispose of clinical waste. And the area provided a confidential environment so that people could speak freely with the pharmacist and the other team members during private consultations.

Team members had organised the benches in the dispensary for different tasks. And a separate rear area provided extra space for dispensing multi-compartment compliance packs and other prescriptions. Sinks in the main dispensary and at the rear of the pharmacy were available for hand washing and the preparation of medicines. And a dedicated area for comfort breaks was available for team members to use. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it removes medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had a slight ramp at its entrance, and this provided unrestricted access for people with mobility difficulties. Services and opening hours were advertised at the front of the pharmacy. And some health information leaflets were on display for self-selection. The pharmacy was offering appointments for flu and Covid vaccinations. And team members had identified appropriate times during the week when it was quieter to provide them. This helped the pharmacy team manage their workload and maintain service continuity.

Team members kept stock neat and tidy on a series of shelves. And they used secure cabinets to store some items. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members checked expiry dates at least once a month. Sampling showed stock items were in date. A large fridge kept medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the accepted range. Team members checked the company's online system for drug alerts. And they updated the system once they had carried out the necessary checks. The system showed a few alerts to be actioned, but the RP provided assurance they had been actioned but not confirmed due to annual leave. The pharmacy used medical waste bins and CD denaturing kits. And this supported the pharmacy team to manage pharmaceutical waste. Not all team members knew about valproate medication and the Pregnancy Prevention Programme for people at risk. They knew to supply patient information leaflets. But they were unsure about the need to supply the extra patient cards. The pharmacist confirmed that patient cards were always provided following the final accuracy check.

Team members had organised the dispensary to keep their working environment safe. The pharmacist positioned themselves so they could supervise the medicines counter. And team members worked at the various workstations depending on the tasks they were carrying out. Dispensing baskets kept medicines and prescriptions safely contained during dispensing. And this managed the risk of items becoming mixed-up and the risk of dispensing mistakes. The pharmacist attached information stickers to some prescription bags. And team members responded to the information, such as retrieving and adding refrigerated medicines and alerting the pharmacist so they could provide extra counselling, such as for new medications.

The pharmacy dispensed medicines into multi-compartment compliance packs to help people with their medicines. And it had procedures in place to manage dispensing to keep services safe and effective. Team members referred to people's medication records to check new prescriptions for accuracy. And they contacted the surgery to confirm any changes. Team members attached 'backing sheets' to the packs. The sheets listed the medications inside and provided the necessary information to meet labelling regulations. Team members supplied patient information leaflets and annotated the backing sheets with descriptions of the medicines. The pharmacy dispensed prescriptions for people in

a nursing home. Team members dispensed the prescriptions all at once and they followed procedures to safely manage dispensing. This included forward planning to make the best use of the pharmacy team's time and to order medications in advance. The pharmacist and the trainee pharmacist dispensed instalments of some medicines on a weekly basis. And the pharmacist carried out an accuracy check at the time of supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its facilities to suitably protect people's private information. It has the equipment it needs to provide safe services. But it does not always have robust processes in place to show that equipment is fit for purpose.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse treatments. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy provided blood pressure checks. But team members could not show when they had last renewed the monitor. So, they would not be able to tell when a new one was needed or whether it was reading accurately.

The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.