General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 107-109 Chapelton Drive, Polbeth, West Calder, West Lothian, EH55 8SQ

Pharmacy reference: 9011044

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

This is a community pharmacy in a village. It relocated into larger premises on the same street beside other shops nine months ago. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. The pharmacy supplies medicines to a care home.

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 follow written processes for services to ensure they are safe. They record mistakes to learn from them. They review these and make changes to avoid the same mistakes happening again. The pharmacy keeps the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. The superintendent pharmacist had reviewed them six months previously and most team members had read and signed them. The pharmacy did not have evidence of the Saturday only assistant reading the SOPs. (Evidence of the driver reading and signing SOPs was not seen during the inspection. But the pharmacy manager provided this to the inspector b later.) Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing well, with coloured baskets used to differentiate between different prescription types and separate people's medication. When the pharmacy introduced new services or processes, team members completed training and had access to support to ensure the new service was implemented affectively and safely. A recent example was 'Yourmeds' compliance packs. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had phone numbers for head office and other branches readily accessible for support. The pharmacy had records of a health and safety audit. But this had been carried out four years previously before the pharmacy had re-located to the current premises.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them, although none were observed. They reviewed these monthly and discussed within the team. The team had not identified any patterns or themes but separated similar sounding medicines. The pharmacy did not dispense a high volume of medicines and team members did not have many incidents. The pharmacy had a complaints procedure and welcomed feedback.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. Most team members had read a SOP on confidentiality, child protection and vulnerable adults. But not the Saturday assistant or delivery driver. Although a team member recalled the delivery driver reading a SOP, but this may have been a previous version. Some team members were not aware of the general data protection regulations (GDPR). And they were keeping some personal information longer than the regulations would suggest. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members knew how to raise safeguarding concerns. The pharmacist was PVG

registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services. Team members have access to training material to ensure that they have the skills and knowledge they need. The pharmacy gives them time to do this training and reading. Team members can share information and they discuss incidents. They learn from them.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, 3 part-time dispensers (20, 20, 28 hours per week), one Saturday only trainee medicines counter assistant and one part-time delivery driver. Typically, there were two team members and the pharmacist in mornings and one team member and the pharmacist in afternoons. Two mornings per week the pharmacy had three team members and a pharmacist. They undertook activities such as assembling instalment prescriptions, some administration and housekeeping tasks on these days. Team members were able to manage the workload.

The pharmacy provided protected learning time for all team members to undertake training and development as required. Team members had access to the CPD hub and head office encouraged them to undertake two modules of their choice per month. Team members described using modules relevant to the time of year e.g. hayfever, coughs and colds, and Lyme disease. Recently all team members had received training on the new computer system and 'Yourmeds' compliance packs. All team members attended an annual training conference which was being held the week of inspection. Head office provided information and updates and invited speakers from external companies to provide topical information for all team members at these events. Team members had annual development meetings with the pharmacy manager to identify their learning needs. Recently they had all focused on the 'Yourmeds'. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this monthly newsletter. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, small dispensary, and back shop area including storage space and staff facilities. The team kept the back-shop area locked. Team members used it for management of 'Yourmeds' multi-compartmental compliance packs, and storage of dispensed care home medicines prior to supply. The premises were clean, hygienic and well maintained. There were sinks in the back-shop area, and toilet. These were clean and had hot and cold running water, soap, and clean hand towels. The team used the back-shop sink for dispensing tasks, such as pouring water to re-constitute medicines and washing dispensing equipment.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. It was accessed from the retail area and the dispensary. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. 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 some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy was accessed by a level entrance, and team members occasionally helped with the door if required. A bell rang as the door opened to alert team members who may not have heard people entering the pharmacy. Team members used a CCTV monitor in the dispensary to watch for people entering the pharmacy. The pharmacy listed its services and had leaflets available on a variety of topics. It could provide large print labels for people with impaired vision. Team members wore badges showing their name and role.

The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. It provided multi-compartmental compliance packs, including some with built-in reminders as part of a trial, to help people take their medicines safely. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members usually had packs prepared a week before the first one was required. But at the time of inspection a pack was being completed for supply the following day. The pharmacist had capacity to check this so there was no increased risk. The previous week the care home medicines had been assembled. The pharmacy did this one week out of four, and it often caused a slight delay to compliance packs' assembly. Team members kept thorough records of interventions and changes, reprinting and dating dose regime templates following changes. Prescribers notified the pharmacy of changes using a bespoke form, and these forms were retained with patient records. Team members checked prescriptions against templates to ensure all expected medicines had been prescribed. They queried any missing or unexpected items with prescribers. The pharmacy stored completed packs in named boxes on dedicated shelves in the dispensary. Team members included tablet descriptions on backing sheets and date of supply on the packs. And they labelled the storage boxes with day and method of supply. They supplied patient information leaflets with the first pack of each prescription.

The pharmacy was working with the local council and the supplier of 'Yourmeds' supplying a small group of people as part of a trial. These were multi-compartmental compliance packs incorporating an electronic reminder system. People provided with these packs previously received their dispensed medicines from other pharmacies and had been selected for a trial by the council. They were assessed for suitability prior to commencing the trial, then taught how to use the packs by a pharmacist or pharmacy technician. They received visual and audible reminders, and selected designated people to be contacted if they did not take their medicines. The pharmacy team members had received training to enable them to set up the devices and support people using them.

Team members were supported internally and from the company supplying the devices to address any issues. A company director met regularly with the council to monitor how beneficial this service was to people. They planned to evaluate it at the end of a three-month period. People who did not find the device suitable were taken off the trial and the pharmacy contacted their original pharmacy to re-instate the previous supply method. The pharmacy also provided pharmaceutical services to care

homes. Team members dispensed in original packs one week in four. A pharmacist checked these then placed each person's medicines in a labelled bag and packed these in boxes for the different areas of the home. The pharmacy used an online system also used by the home which recorded supply of medicines to the home and medicines administration to people.

The pharmacy could see stock levels, and this often avoided phone calls querying quantities ordered. The pharmacy and care home found this a useful tool providing a complete audit trail of medicines management. The pharmacy entered medicines onto the system after they had been checked in the pharmacy, and the home confirmed this on receipt. The home sometimes received medicines from other pharmacies at weekends or 'out-of-hours' and care home staff entered these on to the system, so this pharmacy had visibility of all medicines in use. The pharmacy supplied a variety of other medicines by weekly instalment. A team member dispensed all instalments then a pharmacist checked and bagged, with date of supply on bags. The pharmacy stored these in baskets labelled with person's details and day of supply. It kept records of supply.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they used designated areas for dispensing and checking. The team member labelling highlighted changes or interactions to the pharmacist. They did not need to check previous dates of dispensing, as the GPs did not prescribe if people ordered too early. The pharmacist used labels to identify medicines requiring special storage, or if the pharmacist needed to speak to the person about their medicines. The pharmacy mainly dispensed medicines from prescriptions received from the surgery, with a small volume of 'walk-in' prescriptions. Team members kept people's repeat ordering forms in the pharmacy and used these to order prescriptions. People phoned the pharmacy to order their medicines and the team member made a record in a diary of prescriptions ordered. Team members recorded when these were received form the surgery. They also recorded if the GP had not prescribed for any reason and explained this to the person.

A team member collected prescriptions from the surgery mid-morning and most of these were dispensed before the pharmacy closed for lunch, while there were two team members and a pharmacist working. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings the following day using a documented owings system. Some dispensed medicines had been on retrieval shelves for up to three months, but team members knew these people and were not concerned about compliance or concordance. The pharmacy did not supply any medicines from chronic medication service (CMS) serial prescriptions. The pharmacist sometimes registered people for the service. The regular pharmacist was not present during the inspection, so no interventions or outcomes were discussed.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. A team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had no people in the 'at-risk' group. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given 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. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and chlamydia treatment. The relief pharmacist working did not often work in this health board area so planned to review the PGDs and take appropriate action if she was not signed up to any. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within

their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. They used a template to capture personal details, symptoms and recommendation.

All team members except the Saturday medicines counter assistant delivered the smoking cessation service. They had all been trained and were competent.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, Ethigen and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). Team members had not received any training but had basic knowledge. The pharmacy had the required equipment but there had been issues with the software. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty 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 kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was new. Team members kept crown stamped and ISO marked measures by the sink in the back-shop area and separate marked ones were used for methadone. They kept clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets. The pharmacy had the software, chargers and two electronic devices per person for the trial being undertaken with 'Your Meds' compliance packs.

The pharmacy stored paper records in the dispensary, back-shop area and consultation room, inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented people's information being seen by any people. Team members used passwords to access computers and never left them unattended unless they were locked.

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.