General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 5 Canal Road, Winchburgh, Broxburn, EH52 6FD

Pharmacy reference: 9011065

Type of pharmacy: Community

Date of inspection: 08/08/2019

Pharmacy context

This is a community pharmacy in a new purpose-built unit in an area expanding with new-build houses, retail premises, schools and a marina. The pharmacy re-located into this building two months previously. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs. It has an automated prescription collection point, 'Pharmaself 24', that enables people to collect their dispensed medicines at any time, including when the pharmacy is closed.

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 complete training and implement documented processes to be followed for new services. Only trained and skilled team members use the equipment related to new services. Team members record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. Pharmacy team members discuss this to make pharmacy services better. The pharmacy keeps all 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/tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pre-registration pharmacist who had recently started working in the pharmacy had not yet read the SOPs. The pharmacy superintendent reviewed them every year and signed them off. 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 pre-registration pharmacist was clear what processes she could not undertake e.g. assembly of multi-compartmental compliance packs. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a 'Pharmaself 24' robot which was an automated machine that people could use to collect their dispensed medicines at any time. Team members described possible risks associated with this procedure and how they addressed them. Several team members had received extensive training and followed processes described in a comprehensive manual. They kept the manual close to the machine for ease of use. They knew how to get support if there was any difficulty. This was observed during the inspection as there was a malfunction following a power cut. The issue was resolved very quickly over the phone. People using the machine were shown how to use it and given written information. They signed an agreement before any medicines were placed in the machine. The pharmacy sent a single use code to people to collect their medicines. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

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. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. They had recently changed to an online tool which analysed the data and provided a summary. The pharmacy had recently re-located to this premises, and the pharmacist started working in the pharmacy at that time. So, a review using this system had not yet been undertaken but was planned. Team members described constant review and alteration to work-flow and storage of medicines and sundries as they settled into the new premises and new ways of working.

The pharmacy had a complaints procedure and welcomed feedback. The inspector observed several examples of positive feedback – people using the 'Pharmaself' machine were very positive when asked. They described advantages such as convenience and not having to queue for regular medicine. One person had entered the code incorrectly so came into the pharmacy. The pharmacist offered to retrieve his medication from the machine. But the person asked for another code to be sent. This was more

time consuming for him, but he explained he wanted to feel confident with the process. He easily obtained his medication when he received the new code. The pharmacy team knew how to set this up. The pharmacy undertook surveys which people completed, and these were sent to head office. Some people had commented that the previous premises were too small and cramped and there was no parking. The recent location had addressed both points – the premises were larger and there was ample parking. One person had recently commented that the new premises were too far away, so the pharmacy had offered the delivery service.

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. Team members signed any alterations to records, so they were attributable. 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. They had all read a policy when starting employment except the pre-registration pharmacist who had not done this. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. An example was described of a concern shared with the person's GP. The GP arranged for other services to intervene and the situation was addressed and resolved. The pharmacists were PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services. It compares staff numbers and qualifications to workload and makes changes as necessary. This ensures skilled and qualified staff provide pharmacy services. Team members 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 discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; one full-time pre-registration pharmacist; two full-time dispensers; 1 part-time medicines counter assistant and a part-time delivery driver. The pharmacy had recently recruited a part-time trainee medicines counter/dispensary assistant who would be starting in a few weeks. Typically, the pharmacy had two dispensers, one medicines counter assistant and the pre-registration pharmacist working at most times.
The pharmacist had started in this pharmacy around two months previously, the week before the relocation. Team members were able to manage the workload. At the time of inspection there was a recently qualified pharmacist who was new to the business working as second pharmacist. He was spending an induction week in different branches, sometimes as second pharmacist and sometimes as responsible pharmacist before relocating to another area as pharmacy manager. There was also a relief dispenser working, partially covering for the medicines counter assistant's annual leave, and supporting the pharmacy to allow the responsible pharmacist to spend time with the training pharmacist. The pharmacy had team members' certificates of qualification. The pharmacy reviewed staffing levels and the pharmacist described continuing to do so as business may increase with the ongoing building locally. It used rotas to monitor and manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. And there were relief dispensers that the pharmacist could request.

The pharmacy provided about half hour protected learning time for all team members to undertake regular training and development in line with their own needs. They had access to a range of electronic modules and kept records of what they had done. Topics included child fever, women's health and smoking cessation. They had not done these over the past two months as they had been busy with the re-location and new ways of working. Team members supported each other and were observed coaching and demonstrating tasks to the pre-registration pharmacist. The pharmacy provided a half-day per week protected learning time for the pre-registration pharmacist. Team members had development meetings/appraisals to identify their learning needs. They had development plans in place and objectives included learning processes and service delivery e.g. management of multi-compartmental compliance packs, and smoking cessation. 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. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

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 incidents and errors. They could make suggestions and raise concerns to the manager or area manager. The company had a whistleblowing policy that team members were aware of. The pharmacy superintendent sent quarterly updates which team members read and signed. A variety of topics were included such as new electronic records, new staff role (area managers), falsified medicines directive (FMD) update, NHS services updates, incidents/accounts of events from other branches, near miss shares for information e.g. incorrect delivery and double checking. Teams were encouraged to share and discuss this information. The company had a WhatsApp group that was used for sharing information such as similar packaging with all teams. Team members took care never to share sensitive or confidential information. The pharmacy team discussed incidents and how to reduce risks. The team had occasional team meetings. The company set targets for various parameters, but team members explained that these did not have a negative impact on people. They explained that they only offered services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. The pharmacy team members use private rooms for some conversations with people. People cannot overhear private conversations. The pharmacy protects people's information. The pharmacy is secure when closed. The pharmacy team members raise concerns if there is damage to the premises. The pharmacy addresses this appropriately.

Inspector's evidence

The pharmacy was in a new building beside other shops. It was modern and professional in appearance. These were reasonably sized premises incorporating a retail area, and dispensary. The dispensary had been designed to provide two areas, one at the rear with less distraction so used for management of multi-compartmental compliance packs. The premises were clean, hygienic and well maintained. A leak had developed in a storage cupboard the previous day during exceptional rain. The pharmacist had notified head office and it was being addressed. Team members had moved items stored in this area to protect them from the water. There were sinks in a consultation room, staff toilet, and two sinks in the dispensary, one for medicines and one for staff use. These had hot and cold running water, soap, and clean hand towels.

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 two consultation rooms. One had a desk, chairs, sink and computer. The automated prescription collection robot was accessed from this room. It was locked, discreet and professional looking. The other had a desk and chairs and was used frequently. They were both clean and tidy, and the doors closed providing privacy. The doors were kept locked to prevent unauthorised access. 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 service. The pharmacy team give people information to help them use their medicines and they provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy uses automation in an effective and safe manner. And the pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and wide door. Team members helped people with the door if necessary. The door was visible from the medicines counter and dispensary. The pharmacy listed its services and had leaflets available on a variety of topics. Team members described strategies used to help individual people – one person had particular communication needs that were best addressed by a named team member, although others were developing ways to communicate; there were a few people who had significant hearing impairment so team members described speaking slowly while facing them to help them lipread; team members repacked aspirin tablets into bottles with plain tops for someone who had difficulty opening the blister packaging; and large print labels were provided for people with visual impairment. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines, with additional signatures obtained for controlled drugs. There was an electric cool box plugged into the delivery vehicle to maintain the cold chain of items requiring cold storage. The delivery driver had a delivery sheet with people's name and address on it and labels highlighting additional items such as controlled drugs and fridge items. The pharmacy kept these sheets for three months.

Pharmacy team members followed a logical and methodical workflow for dispensing with dedicated dispensing and checking benches. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Most prescriptions were received from surgeries and a team member separated these into three baskets – deliveries, items to be ordered and others. One team member labelled while another dispensed and deliveries were prioritised. They interrupted this process at a convenient time to dispense medicines for people waiting. They printed all warning labels e.g. highlighting new items, which enabled the pharmacist to undertake clinical assessments. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. A few people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people came to the pharmacy. The pharmacy stored CMS prescriptions in chronological order in a box file which was checked each week to monitor compliance. No issues had been identified. The pharmacy was actively registering people for CMS and all team members were trained to fill in the questionnaire with people. Sometimes the pharmacist identified pharmaceutical care issues when discussing people's medicines with them, but no major issues had been identified so far. The pharmacy managed multi-compartmental compliance packs in the rear area of the dispensary where there was little distraction. A team member demonstrated and explained the process which was thorough and followed a standard operating procedure. Assembly and storage took place in the one area where records and sundries were also stored. This was managed on a four-weekly cycle with four assembled at a time, at least a week before

the first pack was supplied. The pharmacy supplied four packs at a time to some people, including schedule 3 controlled drugs. Prescriptions stated, 'dispense weekly'. The pharmacy undertook assessments including notifying GPs and kept records. But prescribers did not provide written authority. Two dispensers were trained and competent to manage this process and took alternate weeks. They included tablet descriptions, instalment number and date of supply on backing sheets. They left packs open for the pharmacist to seal as she carried out the accuracy check. They also left packaging to facilitate the check. The pharmacy supplied patient information leaflets (PILs) monthly. The pharmacy did not use the automatic collection point for all medicines. Team members did not put instalments, multi-compartmental compliance packs, fridge items or controlled drugs into it. They explained to people that these items must be collected from the pharmacy or delivered. Team members had had a full day training and had a manual to refer too. They got authority from people to put their medicine into the robot. It was very secure, and a SMS message was sent to people's mobile phones to access their medicine. If people did not collect their medicine after four days another text was sent, and if they did not collect it within 24 hours medicines were removed from the robot and placed onto standard retrieval shelves.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the valproate pregnancy prevention programme in place. The pharmacist was very aware and described counselling but had only been in the business a few weeks so did not know if a search for people on valproate had been done. The pre-registration pharmacist was also aware. 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 team members had received training to enable them to provide this information. Doctors often included this information on prescriptions, so it was on dispensing labels. 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, chloramphenicol ophthalmic products and chlamydia treatment. 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 completed a consultation form with patient information, symptoms and recommendation which was included with the prescription and medicine for checking by the pharmacist. They referred to the pharmacist as required.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment available, but training had not yet been undertaken. 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. The pharmacy team members raise concerns from equipment is not working and the pharmacy acts in a positive way.

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 a consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board. Team members kept Crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They also kept clean tablet and capsule counters in the dispensary and had a separate marked one for cytotoxic tablets. The pharmacy had access to support for the automated prescription collection point. Team members knew who to contact and an issue identified during the inspection was resolved quickly over the phone. The pharmacy stored paper records in the dispensary inaccessible to the public. Team members used passwords to access computers and never left them unattended and 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.