General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 9-11 Roseburn Terrace, Edinburgh, Midlothian, EH12 5NG

Pharmacy reference: 9011128

Type of pharmacy: Community

Date of inspection: 04/12/2019

Pharmacy context

This is a community pharmacy beside other shops on a main road close to city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines. The pharmacy offers seasonal flu vaccination and blood pressure measurement. It had re-located to these premises around eight months previously.

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 all services to ensure they are safe. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy uses feedback to improve services. The pharmacy keeps all the records that it needs to and keeps people's information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) online which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept signature sheets as a record of this. The pharmacy superintendent reviewed SOPs every two years 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 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 business continuity plan to address maintenance issues or disruption to services. It had phone numbers for all other branches and suppliers on the dispensary wall.

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 used an improvement tool for review. This enabled the team to quantify errors and identify trends. One month a team member made the same error three times. The pharmacy provided training on the item which eliminated this error. Error with quantities were common, so this was discussed, and attention drawn to pack sizes. Some quantities were ambiguous, so team members were advised to double-check when there was any doubt. The team had put labels in front of some products to remind team members to check strengths e.g. Madopar and lansoprazole.

The pharmacy had a complaints procedure and welcomed feedback, particularly via the website. Team members knew to provide head office details if anyone made complaint. But no examples could be given. The medicines counter assistant described moving retail merchandise from a high shelf when people were unable to reach it. The pharmacy ordered items for people e.g. Savlon cream 100g.

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. The pharmacist had introduced a colour-coded system for filing which was observed to be very organised and easy to use.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern

locally and had access to contact details and processes. The local flow-chart was on the wall. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time at work to do this training. 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 is happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, a regular relief pharmacist (the previous manager), one full-time dispenser, one full-time trainee medicines counter assistant, and one Saturday only foreign pharmacist undertaking dispensary and medicines counter training, and a delivery driver shared with other branches. Typically, there were two team members and a pharmacist working, as there was during the inspection. Team members were able to manage the workload.

The pharmacy provided learning time during the working day for all team members to undertake training and development. It provided team members undertaking accredited courses with additional time to complete coursework. And the trainee medicines counter assistant described undertaking some of this at home. The pharmacist had good visibility of the medicines counter and was observed to supervise the trainee who was able to ask for help and advice. Both pharmacists had undertaken appropriate training for flu vaccination, including having a colleague witness their first vaccination of the season. The full-time pharmacist was trained to deliver NHS vaccination as part of a local pilot. The pharmacy provided access to NPA online training modules for all team members to use. The dispenser described undertaking a module recently about colds and flu.

Team members had development meetings, and these included discussing how workload was managed. The dispenser described being able to bring up any issues. An example was related to Saturday activities. When multi-compartment compliance packs were checked on Saturdays they were not always put away. This impacted the workflow on Mondays. So, it was being managed. The various individuals were observed going about their tasks in a systematic and professional manner. They had a very pleasant manner with people, being polite and clear. 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. The trainee medicines counter assistant described restrictions on the quantity of decongestant tablets supplied and would refer to the pharmacist if there were repeat requests. The pharmacist counselled people and ensured they knew how to take their medicines as she supplied them.

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. They could make suggestions and raise concerns to the manager or area manager. The pharmacy superintendent sent regular communications including quarterly reports. These included drug shortages information and the Community Pharmacy Scotland guidance, inspection information, and examples and case studies of incidents across the company. He also sent a monthly bulletin sharing errors, and weekly branch updates. All team members were aware of these and read them. The pharmacy team discussed incidents and how to reduce risks. The company had a whistleblowing policy that team members were aware of. The company set targets for various

parameters. Team members described how they used these as a reminder to ensure people were offered services they would benefit from.

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 hear these conversations.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and basic staff facilities. The premises had limited storage space. The dispensary was small and divided into two areas. Pharmacy team members used the front area to dispense medicines for people waiting and check prescriptions. Other prescriptions including those for multi-compartment compliance packs were dispensed in an area at the back. The premises had a basement accessed by a hatch on the dispensary floor. But this was not used, mainly because the stairs down were very steep. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff area, consultation room and toilet area. These had hot and cold running water, soap, and clean hand towels.

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

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. The pharmacy gets medicines from reliable sources and stores them properly. 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 team members helped people with the door – this was observed. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination. It could provide large print labels for people with impaired vision. 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. It often delivered owings to people – team members offered this service. The pharmacy put notes onto a multicompartment compliance pack for the carer of a person with impaired vision if tablet descriptions changed. Team members spoke slowly and clearly while facing a person who lip-read due to impaired hearing.

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. The dispenser described sharing information such as new medicines and unexpected dates of supply, with the pharmacist. She wrote notes on prescriptions and attached a 'see pharmacist' label. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy had some dispensed medicines on the retrieval shelves for a few months. The dispenser knew people and could provide explanations. It was therefore unlikely that people had been without their medication.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. The pharmacy was actively registering people for the chronic medication service (CMS). People either completed the template at home and then spoke to the regular pharmacist, or she completed forms with people in the consultation room. She was not present to provide examples of pharmaceutical care identified.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members kept robust records of changes and interventions and re-printed sheets with each addition. They kept archived sheets clearly marked as such. They printed backing sheets after assembly in order to update tablet descriptions if necessary. The surgery returned re-order forms with prescriptions and a pharmacy team member checked that all required items had been prescribed. She queried any omissions in a timely manner. The pharmacy included patient name, date of supply and instalment number on backing sheets and the spines of the packs. It supplied patient information leaflets on with the first pack of each prescription. Several people had similar names, so the pharmacy stored their packs at opposite ends of shelves to minimise the risk of a supply error. It stored completed packs in named box files on shelves by delivery day and separated depending on collection or delivery. A team member added controlled drugs on the day of supply, and left unsealed trays covered and flat in baskets until then. The pharmacist checked these packs individually before supply.

The relief 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. She explained how she would advise people. She did not know if people receiving valproate had been counselled or advised – there were a few people regularly prescribed this. The medicines counter assistant was not aware of the non-steroidal anti-inflammatory drug (NSAID) care or 'sick day rules'. The team did not know if the regular pharmacist had implemented these. 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, flu vaccination and chlamydia treatment. It also followed private PGDs for flu vaccination. 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. Team members completed a template with personal details, symptoms and recommendation and advice.

The regular pharmacist provided flu vaccination privately and as part of a local NHS pilot. The relief pharmacist provided private vaccinations. As noted above, their training was up-to-date. They had emergency adrenaline available in the consultation room. But the relief pharmacist noted that it was from the recently re-called batch. She removed and segregated it. The pharmacy did not have any other adrenaline in stock. So, the pharmacist told team members that the pharmacy could not offer flu vaccination meantime. Pharmacists measured blood pressure on request. Some people liked to track their blood pressure, so the relief pharmacist had designed a template they could use. The pharmacy held this for some people and others kept their own and brought it to the pharmacy each time. Other branches in the company had adopted this form. Pharmacists also delivered the smoking cessation service.

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 not installed equipment and the team had not received training. 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 personal weighing scales, a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was replaced as per the manufacturer's guidance. It had been replaced a few months previously. The pharmacist also kept placebo inhalers, alcohol gel rub and emergency adrenaline in the consultation room. But the batch of adrenaline observed was subject to a MHRA recall. When the relief pharmacist identified this, she removed it as noted above. Team members kept crown stamped and ISO marked measures by the sink in the dispensary, and a separate marked one was used for water. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets which was seldom used. Methotrexate tablets were supplied in blister packaging.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. 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.