

# Registered pharmacy inspection report

**Pharmacy Name:** Right Medicine Pharmacy, 26 Brandon Street,  
Hamilton, South Lanarkshire, ML3 6AB

**Pharmacy reference:** 9011454

**Type of pharmacy:** Community

**Date of inspection:** 17/03/2022

## Pharmacy context

This pharmacy is situated in a parade of shops in the town centre. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to help people take their medicines safely. The pharmacy also supplies medicines to some people living in care homes. It provides a smoking cessation service, emergency contraception service and a range of other services under the Pharmacy First scheme. The inspection was undertaken during the Covid-19 pandemic.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available electronically. SOPs had been recently updated and team members were due to read through the updates. SOPs were reviewed and updated by head office. They were broken down into sections with team members allocated SOPs depending on their job roles. Team members had read the previous version of SOPs which were relevant to their roles. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members had been provided with personal protective equipment (PPE) and plastic screens had been fitted at the counter.

The pharmacy consistently recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). When a mistake was identified the pharmacist handed the basket back to the team member who was dispensing allowing them to identify their mistake. Near misses were recorded electronically. QR codes were stuck to the wall around the dispensary and team members could use their mobile phones to scan these and record their mistake. The computer in the pharmacy could also be used to record mistakes. The responsible pharmacist (RP) said near miss records were to be reviewed monthly but this had not happened for some time. She had spoken to the trainee pharmacist who was due to start carrying out the reviews. The team discussed near misses as they occurred. The system used by the pharmacy to record mistakes analysed data and showed trends. Dispensing errors were also recorded electronically and discussed with the team. As a result of past errors, the team had labelled shelf edges where medicines with different formulations were stored and had separated some strengths of medicines on the shelves.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and a notice informing people of the procedure was displayed. Complaints were dealt with by the RP who was also the pharmacy manager. Where the matter could not be resolved in store it was referred to the superintendent pharmacist (SI) or head office. Since relocating to the new premises, the pharmacy had received positive feedback from people using its services.

Records for private prescription, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were well maintained. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register. CD registers were kept electronically. CD balance checks were carried out regularly and the system prompted for balance checks to be completed if one had not been recorded.

Assembled prescriptions were stored behind the counter in a screened area and people's private information was not visible to others using the pharmacy. An information governance policy was available and team members had read and signed the SOP for confidentiality. Most surgeries had stopped using fax and communication was via the clinical email address. Confidential paperwork and dispensing labels were segregated and collected by head office for shredding. Safeguarding was covered in the SOPs which team members had read. Team members had also completed training and were aware of when to refer any concerns.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough trained team members to provide its services safely. They receive ongoing and structured training opportunities to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings to do this. This means they can help improve the systems in the pharmacy. The team members take professional decisions to ensure people can safely take their medicines.

### Inspector's evidence

At the time of the inspection the pharmacy team comprised of two pharmacists and three trained dispensers, two of whom worked managing the multicompartiment compliance pack service. Other team members included a trainee pharmacist, an accredited checking technician (ACT), a trainee medicines counter assistant (MCA) and a relief dispenser. Team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The second pharmacist was due to leave, another replacement pharmacist had been recruited. The RP said the new pharmacist was an independent prescriber and once they had started working the pharmacy would offer more services under the Pharmacy First Plus scheme.

On the day of the inspection one of the owners was also working from the pharmacy. He was working to set-up care homes on a new electronic system the pharmacy had introduced.

Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. The trainee MCA referred all multiple sale requests to the RP. She was aware of the maximum quantities of certain medicines which could be sold over the counter.

Individual performance and development were monitored by the pharmacy manager. When team members first joined, they had reviews at months one, three and six. The probation period was six months. Previously appraisals had been informal but now they were of a more formal structure, with specific areas of review and team members given ratings. Team members were also provided with on the spot feedback. There was an opportunity to progress. The ACT had started working at the pharmacy as an MCA.

Team members completing formal training courses were given set-aside time to study during working hours. Team members felt well supported with their course and were able to ask colleagues for help. Ongoing training was completed on an online platform. The company had a learning co-ordinator who usually arranged for training to be completed. However, at the time of the inspection she was on extended leave and the RP was ensuring team members completed relevant training courses. Team members had most recently attended a smoking cessation webinar. Some team members also liked to complete their own independent training. The trainee pharmacist had days where she worked in a hospital and took part in group discussions as well as joining webinars.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Issues and concerns were discussed as they arose. Team members including the RP felt

well supported by head office and felt able to feedback suggestions and concerns to them. Targets were set for the services provided. However, team members said there was no pressure to meet these.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy premises were modern, large, bright, clean, and organised. The dispensary was spacious, there was ample workspace which was clutter-free and clear. Workbenches were also allocated for certain tasks. There were designated checking areas for the pharmacists and ACT. An allocated workbench was used for the management of the multicompartiment compliance pack service. A separate room was also dedicated for storing prepared packs. The pharmacy was in the process of changing the layout of the rooms to create a dedicated space for dispensing medicines for care homes. A sink was available for the preparation of medicines. Hand sanitiser was also available for team members to use. Cleaning was carried out by team members in accordance with a rota.

A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The room was large and a plastic screen was placed at the counter. There was a glass window on the door leading into the room. The RP explained that it was rare that people who were using the pharmacy came past that area but the RP provided an assurance that she would look into getting blinds for the window. There was a separate dedicated area for supervising medication consumption. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. A waiting area was available at the front of the pharmacy away from the main counter. The RP explained that the front door was left open during summer and had also been kept open during the pandemic to ensure there was good circulation of air.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy delivers its services in a safe and effective manner. And people with a range of needs can access the pharmacy's services. The pharmacy takes the right action in response to safety alerts. It gets its medicines from reputable suppliers and manages them appropriately to make sure that they are safe to use.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. There was also easy access to the medicines counter. A hearing loop was available and team members removed their face masks when speaking to people to allow them to lip read if needed. The pharmacy had the facilities to produce large print labels. Services and opening times were clearly advertised. When needed translation applications were used or if people did not speak English, they generally visited the pharmacy with a family member who did. Team members knew what services were available and described signposting people to other providers if a service was not offered at the pharmacy. The RP gave examples where people were referred to their GP following Pharmacy First consultations. The pharmacy had direct contact details for the out of hours service and this helped in making referrals at the weekend. The team had good working relationships with local healthcare providers including practice pharmacists, dentist, district nurse and nurse practitioners. This allowed for any issues to be resolved quickly.

The RP felt that the PGD for urinary tract infections and the Pharmacy First service in general was particularly useful as it was often difficult for people to make an appointment with their GP. She felt that it allowed people to get access to treatment quicker. Information was shared with people's GP. Due to the pharmacy's location in the centre of town the delivery service also meant it was easier for people to get their prescriptions. The pharmacy was located next to the bus station and the RP described a lot of people walked in to ask for advice, particularly during the lockdown. Some people who had been referred on from the pharmacy had been diagnosed with clots and aneurysms.

The pharmacy had a well established workflow in place. Prescriptions were handed in at the counter and passed to the dispensers who processed and dispensed the prescriptions and left them for the pharmacists to check. Walk-in prescriptions were mostly checked by one of the pharmacists. In most cases assembled prescriptions were handed out by the pharmacists, as a result of this the pharmacists had been able to pick up on drug interactions which would have caused the person issues had they taken the medicines. It was very rare that the pharmacists had to self-check. Dispensed and checked by boxes were available on labels which were observed to be used. Colour coded baskets were used to separate prescriptions, preventing incorrect transfer of items between people as well as help to manage the workflow.

There were some prescriptions that the ACT did not check. A stamp was used which was signed by one of the pharmacists after they had clinically checked the prescription. This identified which prescriptions could be checked by the ACT.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The previous pre-registration trainee had completed an audit on the use of sodium valproate as part of this people taking the medication had been contacted and counselled.

Additional checks were carried out when people collected medicines which required ongoing monitoring.

Two years before the inspection the pharmacy had carried out an audit for the substance misuse service. The pre-registration pharmacist at the time had created a questionnaire which was checked by the superintendent pharmacist (SI) and people who ran the substance misuse service. As part of this audit, it was found that people did not generally tell all healthcare professionals of the medicines they were taking which could cause issues with drug interactions. As a result of this the pharmacy counselled people to notify healthcare providers of all medicines they were taking.

Some people's medicines were supplied in multi-compartment compliance packs. Weeks of supply were colour-coded with people assigned to receiving their medicines in different weeks to manage the workflow. Shelves used to store prepared packs were also colour coded. The pharmacy ordered prescriptions on behalf of people for this service. To help organise and manage the service each person had their own separate labelled box which was used to store any prepared packs and notes. A sheet was used to record all the medicines the person was taking and this was compared against the prescription each time. Any changes were updated on the sheet. This ensured that all communication was available for all team members including pharmacists to see. Team members contacted the surgery with any queries. In the event that a person was admitted into hospital their box was placed on a separate labelled shelf and a record was made on the board. Packs were prepared by the dispensers and checked by the pharmacists or ACT. Assembled packs were labelled with mandatory warnings and product descriptions. Patient information leaflets (PILs) were routinely supplied. The pharmacy had an audit sheet which was used to record which team member had labelled the packs, who had clinically checked, who had picked the stock, who had assembled the pack and finally who had checked. This helped with any investigation in the event that there was an error.

The pharmacy had recently upgraded to a new electronic system to manage medication supplies to care homes. At the time of the inspection the owner was in the process of setting up care homes on the system and the pharmacy were changing their layout to accommodate this service. The system allowed care homes to order prescriptions electronically and all prescription forms once received by the pharmacy were scanned and uploaded on to the system this allowed the care home to also access and retain a copy of the prescription. When prescriptions were received from the surgery any missed items were automatically flagged. Dispensing labels were only printed when the barcode on the medication pack was scanned and identified by the system. The generated dispensing labels and bag labels had separate barcodes printed on them. All bag labels were scanned before delivery. The care home was able to track where in the dispensing process someone's prescription was. Care homes were supplied with a handheld device. When the trolley was scanned it brought up a picture of the person who the medication was for. Dispensing labels had to be scanned on administration which created a record to show the medication had been given. Three to four team members had been trained on how to use the system. New SOPs were to be created for the service once the owners and SI had set-up the service and identified the risks. There were plans to recruit a trained ACT to assist with checking these medicines.

The pharmacy followed the service specifications for NHS services. The RP explained patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, and emergency hormonal contraception (EHC) had all been signed. However, these were not available at the pharmacy. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. 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. Pharmacists, the trainee pharmacist, or dispensary team members helped make recommendation for treatment. All consultations were recorded on the electronic system. Entries

were made either by the pharmacist, trainee pharmacist or ACT.

The pharmacy provided a delivery service. Signatures were no longer obtained when medicines were delivered and this was to help infection control. In the event that someone was not available medicines were returned to the pharmacy. The pharmacy had consent to post medicines through the letterbox for some people. A risk assessment had been completed with each person which was reviewed when the person moved. The risks associated with posting medicines were discussed with the RP.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperatures were within the required range for the storage of medicines. The system used to record temperatures highlighted if this was out of the required range. CDs were held securely.

Expiry-date checks were carried out on Saturdays with different sections checked each week, team members completed checking the dispensary in three months. Short-dated stock was marked. No date-expired medicine was found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock and stored securely until collected by licensed waste collectors. Drug recalls were received electronically and showed up as unactioned alerts. The RP also received a separate email notifying her of any alerts.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the right equipment for its services, and it makes sure that it's properly looked after. It uses its equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. Separate measures were used for liquid CDs to avoid contamination. Two medical fridges of adequate size were available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✓</span> <b>Excellent practice</b>	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.
<span style="color: green;">✓</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✓</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.