General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Right Medicine Pharmacy, 19 Dempster Street, Wick, Highland, KW1 5QB

Pharmacy reference: 9012139

Type of pharmacy: Community

Date of inspection: 18/04/2024

Pharmacy context

This is a community pharmacy in Wick. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. 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

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 work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The superintendent pharmacist (SI) defined the pharmacy's working practices in a range of relevant standard operating procedures (SOPs). And they provided electronic versions for team members to read when they needed to. The dates on the SOPs showed when they had been first introduced, and showed when they were next due a review in 2024. Team members signed paper-based records to confirm they had read and understood the SOPs, and the SI and the responsible pharmacist (RP) monitored ongoing compliance with them. The pharmacy employed an accuracy checking pharmacy technician (ACPT) and the SI had introduced a SOP for conducting final accuracy checks. This meant the ACPT knew only to check prescriptions that had been clinically checked and annotated by a pharmacist. A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This meant the pharmacist and the ACPT were able to identify and help team members learn from their dispensing mistakes. This included recording and monitoring errors identified before they reached people, known as near miss errors. They discussed these errors with the pharmacy team to identify any patterns and trends and they agreed actions to manage dispensing risks. This included separating medicines which may be selected in error, such as procyclidine and prochlorperazine.

Team members knew how to manage complaints and discussed them in private in the consultation room when necessary. They also knew to escalate dispensing mistakes that people reported after they left the pharmacy. This allowed the pharmacist to investigate and document their findings in an incident report if necessary. The report also included information about the root cause and any improvements they had made. They shared incident reports with the SI and the other team members, so they learned about dispensing risks and how to manage them to keep services safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a RP notice which was visible from the waiting area. The RP record was not always kept up to date and there was missing information from 01/04/2024 to 09/04/2024. Team members maintained electronic controlled drug (CD) registers and they checked and verified the balances every two weeks. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of private prescriptions that were up to date. They knew to protect people's privacy and the company arranged collections for off-site shredding to dispose of confidential waste securely. The pharmacist regularly discussed safeguarding topics with team members, and this ensured they effectively identified and referred any concerns they had about vulnerable people. For example, when people made excessive requests for codeine-containing medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The SI reviewed staffing levels whenever there were changes to the pharmacy team and new team members had been appointed to replace staff that had left. The pharmacist had been in post at the pharmacy for one year, and a regular locum provided cover when needed. The following team members were in post; a full-time pharmacist, one part-time ACPT, two full-time dispensers, two full-time trainee dispensers, one part-time trainee dispenser and two part-time delivery drivers. The pharmacy had minimum staffing levels in place, and this ensured there was adequate cover when team members were on leave.

The pharmacy had appointed a new team member in September 2023, the pharmacist and a ‘buddy’ colleague supported them whilst undergoing the company’s formal induction period. They helped them with their understanding of SOPs, so they were able to follow them and adhere to the pharmacy’s safe working arrangements. The pharmacist provided protected learning time to support new and established team members undergo necessary qualification training. They tailored the time depending on individual needs, for example, when trainees needed extra support to complete their course work.

The pharmacist had qualified as an independent prescriber (PIP) and they provided the NHS Pharmacy First Plus service. They supported all team members to learn and develop and to understand the requirements of the prescribing service. For example, they highlighted the likelihood of referrals for certain treatments following discussions with the nearby GP practice. This meant that team members knew to refer people to the pharmacist for a consultation. The pharmacist also highlighted safeguarding concerns, and team members knew to refer some people to the pharmacist so they could discuss and monitor their treatment. They also discussed changes to NHS pharmacy first service. For example, following a recent update about the number of items that could be claimed for following a consultation.

The pharmacist encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. Team members provided a few examples, for example, changing the dispensing arrangements for the NHS Chronic Medication Service (CMS) seriel prescriptions. And instead of dispensing prescriptions at the time people requestd them they introduced a systematic approach and dispensed them in advance once a week. This meant they were ready for collection when they were due. Team members understood the pharmacy’s whistleblowing arrangements, and they knew to raise concerns with the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in a new, modern purpose-built premises. The pharmacy team managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. And they had designated areas depending on the various tasks they conducted. This included separate areas for final accuracy checks. A rear dispensary was mostly used to dispense and store multi-compartment compliance packs. This ensured there was sufficient space to layout the required components and safely de-blister medicines before placing them in the packs.

The premises also provided ample storage space and facilities for comfort breaks. The pharmacist had good visibility of the medicines counter and could intervene when necessary. Team members used two consultation rooms that were well-equipped with hot and cold running water. They provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team can show it conducts some checks to make sure medicines are in good condition and suitable to supply. But it cannot provide the necessary assurances that it acts on drug alerts and recalls and there is a need for improvement.

Inspector's evidence

The pharmacy provided access via a level entrance which helped people with mobility difficulties. The pharmacist provided the NHS Pharmacy First Plus service and provided treatments for acute common clinical conditions. They communicated their prescribing decisions when appropriate with the person's GP. This ensured their medical records were kept up to date. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted some monitoring activities to confirm that medicines were fit for purpose. The company expected team members to update the pharmacy's online operating system when they had completed the checks that were due. But some of the records had not been updated and this included expiry date checks. Team members confirmed they checked dates at the time of dispensing to ensure they were in date. Sampling at the time of the inspection showed that most items were in date.

The pharmacy used a large fridge to keep medicines at the manufacturers' recommended temperature. And team members knew to read and record the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. But there were gaps in the records that showed the fridge had not been checked since 13/4/2024 due to a team member's annual leave. The fridge was showing a temperature of 5.5 degrees Celsius at the time of the inspection. Team members kept the fridge organised with items safely segregated and dispensed into clear bags. This helped to carry out extra accuracy checks at the time they were handed out to people.

Team members used secure cabinets for some of its items. Medicines were well-organised and team members knew to segregate items awaiting destruction. The pharmacy's operating system showed drug alerts and recall notifications, but team members had not responded to them. The pharmacist confirmed they received and acted on paper notifications, and they had checked a recent alert for insulin. But they did not keep an audit trail and they were unable to provide assurance they had carried out the necessary checks. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. Containers were colour coded and this helped to prioritise prescriptions according to when they were needed. The pharmacy supplied some people with multi-compartment compliance packs to help

them with their medicines. Two different team members assembled and dispensed the medicines to keep dispensing safe. Supplementary records helped team members manage dispensing to ensure people received their medication at the right time. They referred to records that provided a list of people's current medication and administration time. And they checked new prescriptions for accuracy and kept records up to date. Team members included descriptions of medicines on the packs, and they supplied patient information leaflets (PILs) with the first pack of the four-week cycle.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

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 medicines. They had highlighted the measures, so they were used exclusively for this purpose. A blood pressure monitor was available and had been in use for around six months. The pharmacist knew to contact the SI's office if they needed a replacement. 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 conduct conversations in private if needed, using portable telephone handsets.

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.