General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Edinburgh Pharmacy Foot of the Walk, 3-5 Duke Street, Leith, EDINBURGH, Midlothian, EH6 6AE

Pharmacy reference: 1042654

Type of pharmacy: Community

Date of inspection: 12/09/2023

Pharmacy context

This is a pharmacy located in Leith in Edinburgh. Its main activity is dispensing NHS prescriptions and it provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It also provides other NHS services including the Pharmacy First service. The pharmacy recently changed ownership.

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 has written procedures to help ensure it delivers the pharmacy's services safely and effectively. But, owing to a recent change of ownership, team members had not read them yet. The pharmacy keeps the records required by law. Team members record and discuss their mistakes so that they can learn from them. They know how to keep people's private information secure and know how to act to protect vulnerable people and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that were relevant to its practice. The operations manager was responsible for writing them before they were authorised by the superintendent pharmacist (SI). She explained that due to the recent change in ownership the SOPs had not been fully implemented yet and she was still intending to review them and individualise them to the pharmacy. For example, SOPs were to be annotated to identify which dispensers were authorised to receive stock medicines, and what time the fridge temperature should be recorded. She explained the SOPs were kept in an electronic format online and showed that there were a range of SOPs, including for controlled drugs, recording of fridge temperatures and date checking. Team members had not yet read the new SOPs but there was a plan in place to address this. Team members had some experience from the previous employer and were working under the supervision of an experienced team member of the new company while the new processes were implemented.

The pharmacy electronically recorded near-miss errors identified during the dispensing process so that the team could learn from them. The team member who made the error was responsible for recording the details when it was identified by the pharmacist. Several recent errors had been recorded and some learning points had been identified. The pharmacy team had not yet collated data from the near miss records to identify any trends, but this was planned in future. However, the team discussed errors informally when they came to light. The operations manager explained that these conversations usually involved discussions as to why the error happened, how it could be prevented and what might have happened if the error had reached a person. The pharmacy also recorded errors that were not identified until after a person had received their medication. There was one incident recorded involving an incorrect strength of a medicine. This was supposed to have been reported to the operations manager, but she admitted that it hadn't been. And there were no indications of actions being taken to mitigate the risk of the same or a similar error recurring. So, some learning opportunities may have been missed.

The pharmacy had a roles and responsibility SOP for team members to refer to, if necessary, but this was part of the suite of SOPs still to be actioned. However, a team member was able to describe the tasks he was responsible for and explained that tasks were shared between dispensers. He understood what could and could not take place in the absence of the responsible pharmacist (RP). The RP notice was displayed in the retail area of the pharmacy. The pharmacy did not have a formal complaints policy to advise people how they could make complaints or provide feedback. However, the manager explained how he would attempt to resolve any complaints and, if unresolved, was able to escalate to the SI or the operations manager. Feedback received since the pharmacy had changed ownership had been positive, especially in relation to people not having to queue to see the pharmacist. Current professional indemnity insurance was in place.

The pharmacy kept most records electronically. Records for controlled drugs (CDs) appeared to be in order, and frequent balance checks were completed. A check on two randomly selected CDs matched the recorded balance. Records of the RP were in order. And records of the private prescriptions were up to date, and corresponding prescriptions were kept. Team members were aware of their responsibilities to keep people's confidential information secure. Confidential information was kept separately and was shredded within the pharmacy. The pharmacy had a policy for safeguarding vulnerable adults and children, but this was still to be read by team members. A dispenser explained he had been given training under the previous employers and was able to explain the steps he would take if he had concerns about a person. The pharmacist believed he was part of the PVG scheme and knew the processes to follow if he had a concern regarding someone.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and deliver its services safely and effectively. The pharmacy supports its staff to gain experience and improve their competency. And team members know how to support people to receive help and advice about their healthcare needs.

Inspector's evidence

At the time of the inspection, there was a locum pharmacist, who was the RP, and three trained dispensers. The company provided the operations manager and an experienced dispenser from another branch to support the team with the transition to the new owners and support the team to further develop their experience and skills. Another dispenser was the pharmacy's manager. Additionally, there was a trainee dispenser who, although employed within the pharmacy as a full-time team member, was currently working in another branch to gain more experience. The operations manager explained that all team members would receive this opportunity. Team members from other branches within the company could be utilised to cover dispenser absences if necessary.

Team members were observed to be working well together and the dispensing process was calm and organised. A dispenser was observed helping a colleague by answering questions and explaining why branded medicines were to be dispensed over generics when written on a prescription. Team members asked appropriate questions when selling medicines over the counter. And they knew to be vigilant to repeated requests for medicines liable to misuse and would refer to the pharmacist when necessary. The operations manager had identified an updated training module on manual handling and was in the process of reviewing and implementing the training for team members. No targets had been set in relation to professional services yet as the focus was on ensuring that team members were confident and competent in their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It provides suitable space for the services it delivers. It has a soundproofed room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean, tidy, and free from clutter. And it portrayed a professional appearance. There was a large retail area and a spacious dispensary. The pharmacy extended down into a basement level which held a storage area for non-medicinal items and there was a separate room where dispensing of multi-compartment compliance packs took place. The downstairs walkway areas and storage room needed cleaning and had evidence of cobwebs and feathers on the floor.

Dispensary medicines were stored in drawers and on shelves. And medicines that needed cold storage were stored neatly in the fridge. Team members had begun the process of rearranging the shelves into alphabetical order and tidying them. There was a good workflow and there was sufficient bench space for different tasks to be completed. There was a soundproofed consultation room where people could have private conversations with team members. The room had a desk, three chairs and various lockable cupboards. There was appropriate space in the room to allow services to be provided safely.

The dispensary was mostly screened from view of the public by the medicines counter, which provided privacy for dispensing activities to take place and prevented unauthorised access. And the pharmacist was positioned at a bench so that he could intervene in conversations at the medicines counter if necessary. Staff toilet facilities were generally suitable with hot and cold water and soap for handwashing. However, some areas required cleaning. There was also a sink in the dispensary and consultation room which provided hot and cold water. The temperature was comfortable throughout and the lighting was bright.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages the delivery of its services well. And it has suitable procedures to ensure people receive their medicines when they need them. Team members were aware of their additional responsibilities to ensure that people received the necessary information to take higher-risk medicines safely and effectively. And they mostly store and manage medicines as they should. They generally carry out checks to make sure medicines are kept in good condition and are suitable to supply or are in the process of embedding the checks.

Inspector's evidence

The pharmacy entrance was level, which helped provide access to people with limited mobility or with pushchairs. There were chairs for people to use while waiting for services. There were leaflets on display within the consultation room and the retail area highlighting the services offered, such as the pharmacy first service. And people would be referred to other branches if there were any services required that the pharmacy did not offer. The pharmacy did not offer a delivery service but was still providing deliveries to those people who had received their multi-compartment compliance packs by delivery under the previous owner. The deliveries were organised for the day they were required, and then transferred to another branch which was situated across the street. The driver from this branch would then deliver the packs. The dispenser provided a sheet with each person's name and address label, and he thought that the driver used this and ticked on the sheet when a delivery was made. The pharmacy then retained the sheet in case of any queries.

When dispensing, team members kept people's prescription forms and medicines together in baskets to help prevent errors. And stickers were used to highlight the inclusion of a fridge line or CD, or if intervention by the pharmacist was required. Dispensing labels were initialled by dispenser and checker to provide an audit trail. The pharmacy had a separate storage area for owings and associated prescriptions. The operations manager explained that owed medication generally came in the same day and if something was out of stock, they would attempt to arrange an alternative from the person's GP.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. This service had been reorganised since the takeover and team members reported that it was working well. Team members ordered prescriptions for packs two weeks in advance and kept trackers that detailed how many items had been requested, and how many had returned. This allowed any missing items to be queried with the GP. Each person had a folder which contained information about the times their medication was taken and communications regarding changes to packs. The pharmacy also had a form for recording changes to people's packs. Team members had their collected stock checked by another team member before filling the packs. The pharmacy provided patient information leaflets with the packs, so people had the necessary information to take their medicines. And they included warnings and descriptions of the tablets on the labels to help people identify the individual medicines.

Team members were aware of the risks associated with the use of valproate during pregnancy. There were warning stickers attached to drawers where medicines containing valproate were kept. The pharmacist was aware of the need to counsel people when valproate was supplied and to ensure that the warnings and perforated cards were not covered with dispensing labels. The operations manager checked the patient medication record (PMR) to confirm that the pharmacy did not currently supply

valproate to any people in the at-risk category. A dispenser explained that some people who received compliance packs also received sodium valproate. She explained that valproate was supplied to people separately in clear plastic wallets out with the pack. And she showed an example of a record kept showing agreement with a practice pharmacist for this process. The team were not aware of any additional educational material being available, which meant they were not able to provide the appropriate warnings unless the medicines were dispensed in their original containers. The operations manager agreed to obtain supplies of educational material and warning cards.

Methadone mixture for substance misuse clients was measured using an automated dispensing machine. The medicine was prepared ahead of time and the machine was calibrated when it was in use.

The pharmacy obtained its stock medicines from licensed suppliers. A fridge was used for medicines that needed cold storage. The team recorded fridge temperatures daily and records showed they had been in the appropriate range. The pharmacy was in the process of embedding a procedure for date checking medicines regularly, but all medicines had been checked six weeks previously when the pharmacy changed ownership. There were approximately fifteen small clear plastic bags present in the dispensary where compliance packs were made which each contained loose tablets. Each bag was labelled with the name of the medication and date it has been removed from its original pack or from a compliance pack. But there were no expiry dates or batch numbers written on the labels. The dispenser said she did not use these, preferring instead to obtain the stock medicine from original packs. The operations manager accepted that these medicines should not be used and agreed to dispose of them. Pharmacy only medicines were displayed either behind the medicines counter or in clear plastic boxes within the retail area which were marked for people to ask for assistance. The pharmacy had five controlled drugs cabinets which were secured. And they were kept neat and tidy. The CD keys were kept secure during the day. Medicines returned by people who no longer needed them were disposed of in dedicated bins for collection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to paper and electronic copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). It used stamped or British Standard measuring cylinders that were marked for measuring water and liquid medicines. The automated machines used to measure methadone were cleaned after each use, and more thoroughly monthly. A blood pressure machine was marked with the date of first use which was within the past two years. And there was another machine which appeared to not be in use yet and was marked for staff use only. There were triangles and capsule counters used to count medicines. And a separate one was used for methotrexate. Access to the computer system was password protected. Prescription forms and the associated items were stored in a way which prevented people in the retail area from seeing any private information.

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.