

Registered pharmacy inspection report

Pharmacy Name: Market Street Pharmacy, 22 Market Street,
HADDINGTON, East Lothian, EH41 3JE

Pharmacy reference: 1090665

Type of pharmacy: Community

Date of inspection: 30/11/2023

Pharmacy context

This is a community pharmacy in the town of Haddington in Lothian. It mainly dispenses NHS prescriptions, including dispensing medicines in multi-compartment compliance packs to help people take them at the right time. And it dispenses serial prescriptions as part of the Medicines: Care and Review service. Team members advise on minor ailments and they deliver the NHS Pharmacy First service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines as it should, and this creates risks of unauthorised access. This includes some of its higher-risk medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

Overall, the pharmacy suitably manages risk to help its team provide safe services. Members of the team keep the records they need to by law. They mostly keep people's private information safe. And they know what to do to help protect the health of vulnerable people. They record mistakes they make when dispensing so that they can learn from them.

Inspector's evidence

The pharmacy had a comprehensive electronic set of standard operating procedures (SOPs) to help team members manage risks. And it kept a printed copy of these for team members to refer to. The SOPs had been recently reviewed by the superintendent pharmacist (SI) in November 2023. Team members were in the process of reading the updated SOPs relevant to their roles. They signed a record of competence to confirm their understanding of SOPs. Team members were observed working within the scope of their roles. They were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses on a paper record. They explained errors were highlighted to them by the pharmacist, and it was then their responsibility to enter it onto the record. This allowed them to reflect on the mistake. On occasion, the pharmacist would enter this on the team member's behalf if the error was identified during their non-working hours. Following a recent incident involving the incorrect medicine being supplied, hyoscine had been segregated in the medicines storage drawers to reduce the risk of the incident happening again. The team also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. And these were reviewed by the SI. Members of the team aimed to resolve any complaints or concerns informally. But if they were not able to resolve a complaint, they would escalate to the pharmacist manager or SI. The SI and other members of the head office team visited the pharmacy regularly and worked in the pharmacy on occasion.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was in order. The pharmacy held its controlled drug (CD) register electronically. And from the entries checked, it appeared to be accurate. The physical stock levels of CDs were checked against the balances recorded in the CD register every week. There was a record of patient returned CDs in a register and this was maintained to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate electronic records of private prescriptions were maintained.

A privacy notice was displayed in the retail area informing people how the pharmacy handled their data. Team members were aware of the need to keep people's information confidential. They were observed separating confidential waste in dedicated waste bags which were collected by the pharmacy's head office for destruction via shredding. The pharmacy mainly stored confidential information in staff only areas of the pharmacy and in secure locked cupboards within the consultation room. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. They knew to

discuss any concerns with the pharmacist and had access to contact details for relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to manage its workload. Team members receive the correct training for their roles and they complete some additional regular training to maintain their knowledge and skills. They receive feedback about how they are performing to help them develop in their role.

Inspector's evidence

The pharmacy employed a part-time pharmacist who worked three days per week. A regular locum pharmacist worked as the RP on the other days. Other team members included a full-time technician who had recently been promoted to pharmacy manager. There was an experienced pharmacy team. And there was a current vacancy for a full-time dispenser. Team members had all completed accredited training for their roles or were enrolled on accredited training courses. And their certificates of qualification were on display in the pharmacy. Team members were observed working well together and managing the workload. Planned leave requests were managed so that a maximum of two staff members were off at a time. Part-time staff members supported by working additional hours during periods of leave. And the pharmacy manager could request additional staffing hours from local pharmacies owned by the same company. Team members rotated tasks so that they could be completed effectively during absence periods. And they used a daily rota to help ensure all tasks were completed.

Team members who were enrolled on an accredited training course received protected learning time. And all team members had access to additional learning materials relevant to their roles. They received some learning time during quieter periods. The pharmacy manager had regular formal meetings with all team members where they discussed any learnings from near misses or dispensing incidents and recent drug alerts. And they shared any updates from the pharmacy's head office, which were displayed on a pharmacy notice board. This ensured that the whole team received relevant notifications and learnings. Each member of the team received informal appraisals with the pharmacy manager where they had the opportunity to raise any individual learning needs. There were no targets set for pharmacy services.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests for medicines subject to misuse, for example codeine containing medicines. And they would refer such requests to the RP.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the team maintains them to a high standard. The pharmacy has a private consultation room where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy was clean and organised throughout. The pharmacy workspace was well organised with designated areas for completion of pharmacy tasks and suitable storage of prescriptions. The pharmacist used a separate bench to complete the final checking process in the main dispensary near the retail counter. And there was an additional checking bench on a central island in the dispensary where a second pharmacist could work. The medicines counter was clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. There was a defined area to the rear of the main dispensary to dispense medicines into multi-compartment compliance packs.

A good-sized consultation room was available and it had locked cupboards to store confidential information. This space enabled team members to have private conversations with people if required. There was a clean, well-maintained sink in the dispensary used for medicines preparation and team members had access to other facilities for handwashing. And team members regularly cleaned pharmacy workspaces and staff facilities. The pharmacy kept heating and lighting to an acceptable level. Team members had access to a kitchen area and toilet facilities.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy obtains its medicines from recognised suppliers. But it does not store all its medicines as it should. And this creates risk of unauthorised access. The team carries out checks to ensure its medicines remain fit for purpose. And team members provide services that are suitably managed and accessible for people.

Inspector's evidence

The pharmacy had a level entrance and a manual door to access the premises. It displayed its opening hours and some pharmacy services on the exterior of the pharmacy. The team also kept a range of healthcare information leaflets for people to read or take away, these included information on sepsis and the NHS Smoking Cessation service.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. Team members signed dispensing labels to maintain an audit trail. The team provided owing's slips to people when it could not supply the full quantity prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine. The pharmacy offered a delivery service and kept records of completed deliveries, including CDs.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And they had read the recent National Patient Safety Alert. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack.

A large proportion of the pharmacy's workload involved supplying people's medicines in multi-compartment compliance packs. This helped people better manage their medicines. Team members used medication record sheets that contained a copy of each person's medication and dosage times. They were responsible for managing the ordering of people's repeat prescriptions and checked these against the medication record sheet. They documented any changes to people's medication on the record sheets and who had initiated the change. And they kept a paper copy of any change notifications received from the GP practice. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions and photographs of the medicines which allowed people to distinguish between the medicines within them. The pharmacy did not always supply people with patient information leaflets, so they may not have access to up-to-date information about their medicines. Most of the compliance packs were dispensed at an offsite dispensing hub located at another pharmacy owned by the same company. Here the medicines were assembled into compliance packs and were checked for accuracy. Once received back at the pharmacy there was a second accuracy check completed.

Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The team recorded the date each prescription was due to be collected which allowed the team to dispense medicines in advance of people collecting. The NHS Pharmacy First service was popular. Team members completed a consultation with people before referring to the pharmacist to prescriber a medicines from an approved list of products. The pharmacist supplied

medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD).

The pharmacy obtained its medicines from licensed wholesalers and stored them tidily on shelves and in drawers. Team members had a process for checking expiry dates of the pharmacy's medicines. Short-dated stock which was due to expire soon was highlighted. The team had maintained an audit trail to demonstrate completion but this was last completed in July 2023. A random selection of medicines were checked and no out-of-date medicines were found. The pharmacy had a medical grade fridge to store medicines that required cold storage which was operating within the correct temperature range. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of two and eight degrees Celsius. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove and quarantine affected stock. They returned items received damaged or faulty to manufacturer. The pharmacy had some medical waste bins for pharmaceutical waste but those used for patient returned medicines waste were full. Additional patient returned waste was stored in an area that was accessed on occasion by the public. Other out-of-date medicines and patient returns were also not stored as securely as they should be.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Overall, the pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including electronic access to the British National Formulary (BNF) and the BNF for children. And they had access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. Dispensed medicines awaiting collection were stored in a way that prevented members of the public seeing people's confidential information.

The dispensary was raised above the retail area and computer screens were positioned to ensure people couldn't see any confidential information. The pharmacy had cordless telephones and team members were observed moving to a quieter area of the pharmacy to have private conversations with people.

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.