

Registered pharmacy inspection report

Pharmacy Name: Leith Pharmacy, 7 Great Junction Street,
Edinburgh, Midlothian, EH6 5HX

Pharmacy reference: 9010373

Type of pharmacy: Community

Date of inspection: 27/10/2021

Pharmacy context

This is a community pharmacy beside other shops on a main road near the 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 provides the NHS Pharmacy First and Pharmacy First Plus services. And it supplies a range of over-the-counter medicines. The pharmacy offers services including smoking cessation, and seasonal flu vaccination. This pharmacy was inspected 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
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 suitably identifies and manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law although there are some minor details missing. It keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser available. Team members carried out lateral flow Covid-19 tests twice weekly. The pharmacy had tape on the floor to encourage people to socially distance. It allowed three people on the premises at any time. People were observed queuing outside during the inspection. For most of the time there were around eight people queuing. Several used the pharmacy regularly and were used to this arrangement. The queue was orderly, close to the wall and people were maintaining some social distance. Team members managed the queue and invited people into the premises at an appropriate point to receive their medication or have a discussion with a team member. People using the pharmacy were observed to be very understanding and co-operative. Several people offered to wait outside once they had spoken to a team member on the premises. This worked well. The medicines' counter assistant knew what people's needs were, and she worked with the dispensers and pharmacist to manage the queue effectively. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. The pharmacist had written operational guides for most processes and these provided more detail than the SOPs. These were kept in the area relevant to the task so team members could easily refer to them. These guides included stock management, dispensing processes for different types of dispensing and detailed processes for other service delivery. They were very systematic and included photographs and screen shots. They were particularly useful for team members not familiar with this pharmacy including locum pharmacists. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist, although the pharmacist did not leave the premises during the working day. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. An accuracy checking pharmacy technician (ACPT) checked all prescription types depending on need after the pharmacist had carried out a clinical check and signed prescriptions to signify this. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had phone numbers readily accessible for GPs, other healthcare professionals, other pharmacies, team members, company directors,

maintenance contractors, wholesalers, and drug companies.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They usually reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. They had not managed to do this over the past few months due to some absence. Team members had separated medicines with similar names, and they had placed labels on shelves highlighting items likely to be wrongly selected, such as similar looking pack sizes and medicine forms, for example tablets or capsules. The pharmacy had a complaints procedure and welcomed feedback. Team members regularly monitored reviews on social media. Recently there had been a poor review, so team members had met to discuss it. And they had put a strategy in place to reduce the chance of this type of review in the future.

The pharmacy had an indemnity insurance certificate, expiring 02 May 2022. The pharmacy displayed the responsible pharmacist (RP) notice and kept a responsible pharmacist log. The pharmacist acknowledged that some entries may not accurately reflect when she was responsible as she often came in early. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. Some entries were incomplete. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. The pharmacist kept records of prescribing under the Pharmacy First Plus service.

Pharmacy team members were aware of the need for confidentiality and had all read a SOP. They segregated confidential waste and shredded it daily. 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. They described having the knowledge and competence to act autonomously but would often discuss issues within the team to decide on the best plan. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme. Team members described several examples of dealing appropriately with vulnerable people, including administering first aid, calling ambulances, and referring people to other agencies to help.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. Team members make decisions within their competence to provide safe services to people. And they use their professional judgement to help people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had: one full-time pharmacist manager, one full-time accuracy checking technician (ACT), three full-time and two part-time dispensers, one full-time and one part-time medicines' counter assistants (MCA), and a full-time and two part-time delivery drivers. One driver mainly collected prescriptions from surgeries. Typically, there were at least three dispensers and one MCA working at most times. At the time of inspection there were four dispensers and an MCA. Team members were able to manage the workload. The MCAs were competent to deal with many queries, which took pressure off the dispensers. One dispenser was due to complete her accredited training course this week, and the pharmacy gave her protected time each week to do this. The others were qualified and experienced. All dispensers were trained and competent in all aspects of dispensing and rotated round all tasks to ensure they kept their skills and knowledge up to date. The pharmacy provided learning time during the working day for all team members to undertake regular training and development. It provided this in a variety of ways depending on need and topic. Topics were often related to new services such as Pharmacy First and Pharmacy First Plus. When the pharmacist became an independent prescriber, she started delivering this service, and all team members were briefed and trained. As her experience grew, this service was evolving. So, she continually updated team members to ensure they triaged symptoms and referred to her appropriately. The pharmacist had weekly 1-2-1 meetings with all team members to identify any learning or development needs. And to provide an opportunity for team members to raise any concerns if they had any. They also discussed near misses and errors if there had been any. The pharmacist had undertaken leadership training which equipped her to work closely with team members. Usually, the pharmacy had double pharmacist cover one day per week. The pharmacist used this time to complete routine and administration tasks.

Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. The pharmacist worked much of the time in an area immediately behind the medicines' counter so could hear and see people at the counter. She intervened if appropriate. But this was seldom required as team members were well trained and competent. And they asked for support when they required it. Team members communicated well with people using the pharmacy, other healthcare professionals and colleagues. This was observed on numerous occasions during the inspection. Team members contacted GP practices as required to query prescriptions. They were competent to do this without direction from the pharmacist. And they recorded the outcomes of any calls. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

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. Dispensers described how they drew colleagues' attention to errors, for example medicine selection errors. They made suggestions and could raise concerns to the pharmacy manager, superintendent pharmacist or other pharmacist director. A dispenser who had joined the team recently described the superintendent inviting her to provide feedback on any observations she had. This was with a view of continually reviewing and improving systems and services. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are safe and clean, and suitable for the pharmacy services provided. The pharmacy has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, and spacious basement. The basement included more dispensing space, storage areas and staff facilities. The premises were clean, hygienic, and well maintained. Team members cleaned surfaces and touch points frequently throughout the day. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available. The pharmacy had a contract with a pest control company which inspected annually.

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. This room was large enough for social distancing and this was managed by careful positioning of chairs. The door was kept locked to prevent unauthorised access. The pharmacy also had a separate area for specialist services such as supervision of medicines. People were able to use this during the pandemic as only one person was allowed in at-a-time. And the people regularly accessing this service co-operated with each other to ensure only one person at a time was in the room. Temperature and lighting felt comfortable.

The pharmacy's website provided healthcare advice and information on a range of conditions. It referred to the NHS 'minor ailments' service which had been replaced with the NHS 'Pharmacy First' Service. And it referred to the 'chronic medication scheme' which had also been replaced.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra written information to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members know 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 assisted people with the door if required. They had good visibility of the door from the medicines' counter. And the pharmacy provided a delivery service.

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. Each day a designated dispenser was responsible for routine dispensing of prescriptions received from the surgery. One surgery was very close, so the pharmacy received prescriptions several times a day. At the time of inspection that morning's prescriptions were being dispensed. A logical process was followed, making the process efficient. Another dispenser was responsible for stock control, following the local guide to maximise efficiency when stock was received, putting it away quickly and identifying items required for balances of prescriptions. She also dispensed walk-in prescriptions. A third dispenser managed some instalment dispensing and supervision of some medicine. These processes were observed to be efficient and organised. Team members were very clear what their role that day was. They usually carried out the same tasks each day for a week then rotated to maintain skills. But there was flexibility for them to change task and support each other. Another dispenser mainly worked in the basement managing multi-compartment compliance packs. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day. A few people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these around a week before the due to date to ensure medicines were ready for people as expected. It kept records of when people collected their medicines.

The pharmacy managed the supply and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. A dispenser worked almost full-time on this process. And the ACPT spent a lot of her time in this area. It was undertaken in the basement where there was no distraction. The packs were assembled at another branch which was a hub for all branches in the group. It used automation and the robot was highly accurate. It was set up to check tablets in compliance packs, and the backing sheets had photographs of each tablet on them. Despite this, a pharmacist or ACPT checked the packs for accuracy at the hub. And the backing sheets were initialled by a dispenser and checker to provide an audit trail. The ACPT from this pharmacy worked in the hub one day a week, so she had a thorough understanding of the complete process from receipt of prescription to supply of medicines. When prescriptions were received by the pharmacy, a dispenser checked that all items had been prescribed as expected. Then a dispenser 'labelled' them which sent the information to the robot at the hub. The robot assembled four weeks' packs. The backing sheet had the date of supply and instalment

number on it as well as personal details. And the spine of each pack was labelled with the person's name and the date of supply. The pharmacy had a process in place to signify when packs were expected in the pharmacy. When the pharmacy received the completed packs, a dispenser checked that all items had been dispensed and attached prescriptions to the packs. The pharmacist then carried out a final clinical check. The pharmacy stored completed packs in individual boxes per person labelled with their name and day of supply. The box also contained the prescriptions and records of changes. The pharmacy used communication sheets for each person to record any changes or discussions. And it used prescription request forms if necessary to request items not on repeat forms. The pharmacy supplied medicines in multi-compartment compliance packs to a lot of people, so this process was continuous, every day. There was not enough secure storage to store completed packs containing controlled drugs. So the hub assembled packs with all other medicines and left them unsealed for the CDs to be added. A team member secured them with elastic bands and they were carefully packed flat for transport. The dispenser in this pharmacy placed controlled drugs into packs on the day of supply. The previous day the dispenser checked that the pharmacy had availability of CDs required and ordered them if not. This worked well, minimising stock holding and ensuring stock was available when required. The pharmacist or ACPT checked the whole pack after the dispenser had added the CD. The pharmacist was in the process of reviewing this, to consider if sealing the packs at the hub, then opening them to add CDs would be a better process. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. And the pharmacy stored them in named baskets in the basement. Each day a dispenser placed instalments for the following day into a basket for the pharmacist to check, then they were taken to the dispensary. At the end of the day the basket was taken back to the basement with any uncollected instalments. A dispenser recorded these and took appropriate action. This was variable depending on circumstances and included contacting people and sometimes contacting prescribers. The pharmacy supplied medicines to GP practices on stock order forms. It held an MHRA Wholesale dealer's Authorisation (WDA).

A 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. The pharmacy kept the information beside the medicines to remind team members to include it with the dispensed medicines. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group. The pharmacist had counselled them appropriately and checked that they were on a pregnancy-prevention programme. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for smoking cessation, unscheduled care, and the Pharmacy First service. 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. And they made the appropriate records on the electronic system. The pharmacist had written a guide to some common conditions including photographs to help team members. The pharmacist was an independent prescriber so delivered the Pharmacy First Plus service. She had obtained data from Information Services Division (ISD) to undertake a needs assessment of the local area and identify the top ten conditions that local people saw their GP about. She had then decided on a list of conditions that she was confident to prescribe for. And devised her own formulary based on her competence and the Lothian Joint Formulary. The pharmacist had discussed this with the GPs so that they could make appropriate referrals to the pharmacy. And she had trained the pharmacy team members so that they could triage people with some symptoms or conditions. The team described this as working very well providing timely treatment to people and supporting GP colleagues. The pharmacist was currently providing NHS and private flu vaccinations. Some were by appointment and some were 'walk-in'. The

pharmacy contacted people as stock became available. There had initially been a delay in receiving NHS stock.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, AAH, Phoenix and Ethigen. The pharmacy stored medicines in original packaging on shelves, and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. These were observed to be within 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 accepted obsolete medicines from members of the public. A team member checked bags of medicines to identify any that required secure storage, then took them to the basement. A team member there removed medicines from packaging, separating confidential information, packaging for re-cycling and medicines for destruction. This ensured that space was well used in the waste medicines receptacles.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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 to deliver its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had resources 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 a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was replaced as suggested by the manufacturer. The team was not using the carbon monoxide monitor during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy used a 'Methameasure' pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes each morning when it was set up. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and basement, inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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.