

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: 14/06/2023

Pharmacy context

This is a pharmacy on a busy street in Leith in Edinburgh. Its main activities are dispensing NHS prescriptions and providing multi-compartment compliance packs to people to help them take their medicines safely and effectively. It delivers medicines to people in their homes. And team members provide advice and treatment for a range of conditions as part of the NHS Pharmacy First Service. They supervise the administration of some medicines.

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 not all met	1.6	Standard not met	The pharmacy does not keep accurate records for all its higher risk medicines. And it does not resolve problems with the accuracy of these records in a timely manner.
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 not all met

Summary findings

The pharmacy does not keep adequate records for some of its higher risk medicines. And team members do not resolve problems with these records in a timely manner. They record some of the errors they make when dispensing and they learn from these to reduce the risk of further errors. They know how to respond to concerns about vulnerable adults and children. And they keep people's confidential information safe.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help team members work safely and effectively. They were reviewed by the superintendent (SI) pharmacist in March 2023. They had yet to be implemented by the pharmacy. Team members had signed training sheets for previous versions of SOPs to confirm their understanding and compliance with them. The pharmacist was an independent prescriber (IP) and provided both NHS and some private prescribing for people. This included the Pharmacy First Plus Service in line with Health Board requirements. As part of the private prescribing service, the pharmacist had prescribed an unlicensed injection for hayfever approximately two to three times in the last year. There was no risk assessment relating to the potential risks of prescribing this unlicensed medicine. The pharmacist had been using a patient group direction (PGD) but this had been valid when the medication was licensed.

Team members recorded errors identified during the dispensing process known as near misses. The team member who made the error was responsible for recording the details of the error including any potential reasons for the error occurring. The pharmacy's error log had a few errors recorded so they could learn from errors. The responsible pharmacist (RP) confirmed trends were not formally assessed. However, team members had informal conversations to suggest and implement changes to help mitigate the risk of the same or a similar error occurring in the future. They highlighted medicines that looked-alike and sounded-alike (LASA) on the shelves where they were kept, helping reduce selection errors. They electronically recorded errors highlighted after a person had received their medicine, known as dispensing incidents. The RP discussed the details of the incident with the person who made the error, and the report was shared with the SI.

Team members explained how they rotated responsibility for different tasks on a weekly basis. For example, one dispenser was responsible for the preparation and supervision of medicines for the substance misuse service that week, and would have responsibility for another task, such as dispensing, the following week. There were two team members whose sole responsibility was the organisation and dispensing of medicines in multi-compartment compliance packs. This included one experienced dispenser who was upskilling another dispenser so the continuity of service could be maintained during holidays or absences. Team members understood what tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed with the correct details of the pharmacist on duty.

The pharmacy had a complaints procedure which involved people talking to team members or the RP to resolve any issues or concerns. Team members explained how they escalated concerns that could not be resolved to the pharmacy's head office by giving people an email address. A current certificate of professional indemnity insurance was available.

The pharmacy had a controlled drug (CD) registers but not all entries were completed accurately. The pharmacist and trainee pharmacist shared responsibility for completing CD checks on a monthly basis but had not followed up on the accuracy of these checks. The pharmacy kept an RP record, this showed a small number of incomplete entries. It had a private prescription register, but not all private prescriptions had been entered into the register and the incorrect date of supply was captured for other entries. Certificates of conformity for unlicensed medicines known as “specials” were retained but the details of who prescribed and who received them was not always captured to help provide an audit trail.

Pharmacy team members were aware of their responsibility to keep people’s personal information secure. They had access to SOPs which detailed the processes to be followed for information governance (IG) and the General Data Protection Regulation (GDPR). And they kept confidential waste separately for shredding. They had a SOP to refer to about safeguarding children and vulnerable adults. And although they had no formal training, they knew to raise any concerns with the RP. The pharmacy had details of safeguarding contacts to refer to but team members could not confirm if these were up to date.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage the workload and provide its services. And they receive appropriate training and development relevant to their roles. They feedback ideas and make improvements to the way they work. And they feel comfortable raising concerns if they need to.

Inspector's evidence

The pharmacy team at the time of the inspection included the RP, who was the regular pharmacist, an accuracy checking pharmacy technician (ACT), a trainee pharmacist, six dispensers and one trainee dispenser. Additionally, there were two delivery drivers. One dispenser was a recently graduated pharmacy student, who had increased her hours temporarily to support the pharmacy. Team members were seen to be working well together to manage the workload. There were some part-time team members which meant that absences and holidays were more easily covered. The pharmacist received support from ACTs and pharmacists to complete clinical and accuracy checks over four days a week. This consisted of additional pharmacist and ACT cover for two days each.

The pharmacist confirmed the trainee dispenser was enrolled on an accredited training course and that the delivery drivers had also completed accredited training. The pharmacist IP had shadowed other IPs to gain experience before delivering prescribing services in the pharmacy. She attended regular training provided by the Health Board, the most recent involving how to effectively prescribe medication to people who were pregnant and breastfeeding. And team members attended training events organised by the company's head office. Team members were aware of the need to be vigilant to repeated requests for medicines liable to misuse. A dispenser explained she would refer these requests to the RP. And the RP confirmed she would have supportive conversations with the person and would refer them to their GP if needed. They also discussed repeated requests together so that all team members were aware and could monitor the appropriateness of supplies.

The pharmacy did not complete any formal performance reviews with team members. But team members felt comfortable to raise concerns and make suggestions for improvement. For example, a dispenser suggested and implemented changes to the process for organising and dispensing multi-compartment compliance packs. And this was supported by the pharmacist. Team members were not set targets for the completion of services.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are secure, clean, and generally tidy. And the consultation rooms are appropriately sized and suitably equipped for private conversations and the provision of services.

Inspector's evidence

The pharmacy premises consisted of a retail area and small dispensary. There was a larger space in the basement for the preparation and storage of multi-compartment compliance packs. Some areas were clean and tidy. There was some clutter on benches, this reflected the number of prescriptions being dispensed in the pharmacy and how busy the pharmacy was. Team members had their own space in which to complete their tasks.

The pharmacy had two consultation rooms where people could have private conversations with team members and access services from the pharmacist. These were locked when not in use and prevented access to unauthorised people. The main consultation room was used for the provision of services and was soundproofed. It had a sink with hot and cold water, computer facilities and chairs for people. The other room was smaller and used for the supervision of medicine to some people.

The dispensary was protected from public view by the medicines counter and allowed for privacy for various dispensing tasks to take place without distraction. A barrier was in place between the medicines counter and the retail area. The dispensary had two sinks which provided hot and cold water for professional use and for hand washing. And the toilet facilities were clean and hygienic and had facilities for hand washing. The pharmacy was well lit throughout, and the temperature was acceptable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides people with suitable access to its services. And it generally manages its services properly. Overall, it manages its medicines appropriately and stores them correctly. But it doesn't always keep a regular record of the temperature of its fridge where it stores some medicines.

Inspector's evidence

The pharmacy had a step free entrance which provided ease of access to those with limited mobility and with pushchairs. It provided a range of services, including NHS Pharmacy First Plus. The pharmacy had PGDs available for the provision of the Pharmacy First service, although the paper copies of the PGDs were out of date the current versions were available online.

The pharmacy kept a record of medicines delivered to people's homes. And medicines that needed to be kept in the fridge were delivered first. A few people had their medicines delivered through their letterbox and the pharmacy had consent from people to do this. But the consent was not routinely documented and the suitability of doing this was not routinely reviewed to make sure this continued to be a safe delivery method. The risks associated with this were discussed during the inspection and the pharmacist confirmed they would review the process.

The pharmacy team members used baskets when dispensing to keep people's prescriptions and medications together and reduce the risk of errors occurring. They used stickers as part of the dispensing process to highlight if a fridge line or controlled drug or intervention by the pharmacist was required. And team members signed to indicate who had dispensed a medication and who had checked it, so team members involved in each stage could be identified. The pharmacy provided a service where it dispensed and supervised the administration of medicine to some people. Team members prepared doses at the time of arrival for those who had their medication supervised daily. And they ensured that doses for people who collected their medication either weekly or twice weekly was prepared in advance. Team members were aware of their additional responsibilities to provide people taking higher-risk medicines with additional counselling to help them take their medicines safely. They knew to give people taking valproate in the at-risk category patient cards on each dispensing and the pharmacist knew how to counsel people accordingly.

The pharmacy dispensed medicines into multi-compartment compliance packs for a large number of people. A dispenser organised the service by ensuring prescriptions were ordered two weeks in advance of them being dispensed. This allowed time to resolve any queries. The packs were dispensed by automation at another pharmacy within the company that acted as a pharmacy hub. And they were accuracy checked by an ACT at the hub. The packs received back from the hub had descriptions and pictures of medicines printed on the packs. A dispenser explained that packs containing CDs and medicines with specific storage requirements were dispensed at the pharmacy the day before they were due, rather than at the hub. Communications regarding medications changes in people's packs were documented on an individual record. People were not supplied with the information leaflets every time they received their medicines but were supplied with information leaflets for any new medication issued.

The pharmacy used a date checking matrix and it was up to date. Checks on some medicines confirmed

them to be within their expiry dates. And medicines with a short expiry on opening were marked with the date of opening. The pharmacy had one fridge and the temperatures were recorded electronically. The record showed the temperature had not been recorded for the previous two weeks. And upon inspection, the recorded maximum temperature of the fridge had been out with the recommended range. The temperature of the fridge during the inspection was within range. The pharmacist reset the thermometer and confirmed she would remind the team to record the temperature and any action taken daily. Team members kept patient returned medicines separately for disposal, these bins were seen to be overfull. The pharmacy received emails about drug alerts and medicine recalls. These were printed and stored in a folder, but a sample seen had not been signed to show that they had been actioned.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has suitable equipment and facilities to help deliver its services safely and effectively. The team uses its equipment and facilities in a way which protects people's personal information.

Inspector's evidence

The pharmacy had access to up-to-date versions of resources. And it had a range of equipment to use. This included a blood pressure monitor but this had not been marked with the date of first use. This meant that team members may not know when the monitor was required to be calibrated or replaced. This was highlighted during the inspection. The pharmacy used an automated dispensing machine for methadone, which was calibrated and cleaned each day. And it had glass CE marked measures for measuring liquids. There were clean triangles used to count tablets.

The dispensary lay out was designed so that computer monitors could not be seen by unauthorised people. The computer system was password protected. Medicines and prescriptions awaiting collection were positioned so that people's personal information could not be seen. And there was a cordless telephone to enable conversations to be kept private.

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.