General Pharmaceutical Council

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: 08/02/2024

Pharmacy context

This is a community pharmacy on a busy high 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. 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.

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 appropriately manages the risks associated with the services it provides for people. It has a complete set of written procedures which help the team carry out tasks consistently and safely. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

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. Team members 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 they would enter it onto the record after discussion with the pharmacist. This allowed them to reflect on the mistake. Team members explained that after an error, they would implement actions to reduce the likelihood of a similar error happening again. Recently there had been an increase in the incorrect selection of liquid antibiotic medicines. Team members advised that these medicines were stored in a cramped, shelved area ofthe pharmacy. So, they had moved the storage of liquid antibiotics to a larger, more visible shelving area. This had reduced the recurrence of this type of error. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded and then reviewed by the SI. The pharmacy team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the pharmacist manager or SI.

The pharmacy had current 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 compliant. The pharmacy team maintained a dispensary duty log which detailed the team members present and their responsibilities on that day. The pharmacy had an electronic controlled drug (CD) register and the entries checked were in order. Team members checked the physical stock levels of CDs against the balances recorded in the CD register on a monthly basis. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate records of private prescriptions were maintained electronically.

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 confidential information safe. And they were observed separating confidential waste into separate bags to be shredded. The pharmacy stored confidential information in staff-only areas. Pharmacy team members had recently completed learning associated with their role in protecting vulnerable people. And they had access to contact details to relevant local agencies. The pharmacists were members of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient team members with the knowledge to manage its workload and provide its services. The pharmacy supports its team members to complete appropriate training for their role and keep their skills up to date. Members of the team work well together and communicate effectively. And they are comfortable providing feedback and raising concerns should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager, and they were an independent prescriber. Other team members included two full-time dispensers, five part-time dispensers, a part-time medicines counter assistant and a full-time trainee dispenser. And the pharmacy had full-time support from a second pharmacist or a relief accuracy checking technician (ACT). Team members had all completed accredited training or were enrolled on an accredited qualification training course for their role. All team members enrolled on an accredited training course received regular protected learning time. The pharmacy company had recently developed a new role of store trainer who was a full-time experienced dispenser. They provided relief dispenser support in pharmacies owned by the same company where employees were on registered training courses. On the day of inspection, the store trainer was supporting the trainee dispensers and the new relief pharmacist who was completing their company induction. The relief pharmacist had also spent time with members of the head office team to complete company mandatory training and had read the company SOPs and relevant policies and procedures. Team members completed ongoing training that was relevant to their roles, and they were provided with protected learning time to complete this training. The team had recently completed training for delivery of an NHS Nasal Naloxone service, and they had completed online training relating to safeguarding. Each team member had a training record detailing what training they had recently completed.

Team members were observed working well together and managing the workload. Planned leave requests were managed by the pharmacy operations manager who worked at the company head office. Part-time and relief staff supported by working additional hours during periods of planned leave. The pharmacy team received regular visits from the superintendent pharmacist and the other pharmacy owner who had both visited the pharmacy on the day of the inspection. Team members felt comfortable to raise any concerns with their manager. They received regular feedback as they worked. And had an annual formal appraisal with their manager.

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 liable to misuse, for example codeine containing medicines. Team members explained that they had received some requests for codeine linctus. However, they confirmed that they did not sell codeine linctus and did not stock it. There were no targets set for pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. It has private consultation facilities where people can have confidential conversations with a pharmacy team member if needed. The pharmacy is secure when closed.

Inspector's evidence

The premises were secure, modern, and provided a professional image. They consisted of a retail area and main dispensary. And there was a larger space in the basement used for preparation of multi-compartment compliance packs and there were staff facilities and toilet to the rear. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. A bench used by the RP to complete the final checking process was at the front of the main dispensary near the retail counter. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. The pharmacy had a consultation room with a desk, chairs, sink and computer. The room was clean and tidy, and the door closed which provided privacy. Storage in the consultation room was kept locked to prevent unauthorised access. There was an additional consultation room accessed directly from the dispensary area which was used to supervise a substance misuse service.

The dispensary was screened from public view by the medicines counter. It provided privacy for various dispensing tasks to take place without distraction. A lockable 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. Temperature and lighting were kept to an appropriate level throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. It manages its services well and they are easy for people to access. The pharmacy receives its medicines from reputable sources and stores them appropriately. And team members carry out checks to help ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access with a level entrance and a manual door with an automatic push-pad to the main retail store. The pharmacy displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information posters for people to read, these included information on depression and smoking cessation services.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members signed dispensing labels. This helped to identify which team member had dispensed and checked the medicine. The pharmacy offered a delivery service and kept records of completed deliveries including CDs. And they maintained a delivery consent log where people had authorised special access to their properties for example use of a key safe if they were unable to answer the door.

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.

The pharmacy provided multi-compartment compliance packs to a large number of people to help them take their medication correctly. These were dispensed at a hub pharmacy owned by the same company. 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 matched these against the medication record sheet. They documented any changes to people’s medication on the record sheets. The prescription data was entered into the patient medication record (PMR) by a dispenser, it was clinically checked, and accuracy checked by the RP. The data was then transferred to the hub pharmacy for assembly using the automated dispensing machine. A photograph and description of each medication was printed onto the labels and attached to the packs so people could differentiate between the different medicines in the pack. Patient information leaflets were routinely supplied so people had access to up-to-date information about their medicines.

The regular pharmacist provided a flu vaccination and travel vaccination service. They had completed face-to-face vaccination training and on online training module prior to providing the service. And they had read the patient group directions (PGD). The service was managed using an appointment schedule. The NHS Pharmacy First service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a PGD. The pharmacist could access the PGDs electronically and they kept printed copies. The medicines counter assistant asked people relevant consultation questions and then referred to an approved list of medicines before suggesting a treatment option to the pharmacist. The pharmacist then completed the consultation.

Pharmacy-only (P) medicines were stored behind the pharmacy counter to prevent unauthorised access. The pharmacy obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of between two and eight degrees Celsius. The pharmacist advised that team members checked the expiry dates of medicines regularly and were up to date with the process. And the team followed the matrix provided from the pharmacy head office which they signed to demonstrate completion. Medicines due to expire soon were highlighted. A random selection of medicines were checked and all were found to be within their expiry date. 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 manufacturers as soon as possible. The pharmacy had medical waste bins for pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

The pharmacy had access to up-to-date versions of resources including the British National Formulary (BNF) and the BNF for children. And it had access to the internet. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of clean, well-maintained tablet counters. An automated dispensing machine was used to dispense liquid CDs for a substance misuse service. This was calibrated daily and cleaned. And engineer support was available via telephone.

The dispensary was designed so that computer monitors could not be seen by unauthorised people. The computer system was password protected. 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. On the day of the inspection there was a fault with the telephone line. Team members diverted calls to a handheld mobile device to allow people to be able to contact the pharmacy and have private conversations if required.

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.