Registered pharmacy inspection report

Pharmacy Name: Edinburgh Pharmacy, 5 Montagu Terrace, Edinburgh, Midlothian, EH3 5QX

Pharmacy reference: 9011155

Type of pharmacy: Community

Date of inspection: 10/02/2020

Pharmacy context

This is a community pharmacy on a main road close to a city centre. The pharmacy dispenses NHS prescriptions and advises on and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs including assembly as a 'hub' for other pharmacies in the company. It can provide substance misuse services. It offers smoking cessation, flu vaccination and travel services.

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	1.4	Good practice	The pharmacy welcomes feedback. And it uses people's feedback to improve and develop the safety and quality of its services.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	3.1	Good practice	The pharmacy has a bespoke design and layout to accommodate the different services it provides. The team members use the spaces well to manage the different acivities.
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 team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they make changes to avoid the same mistakes happening again. The pharmacy welcomes feedback. And it uses people's feedback to make its services better. The pharmacy keeps all the records that it needs to and keeps people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them. And the pharmacy kept records of this, but one team member had not signed to confirm they had read them. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. And it managed the hub dispensing well with documented process followed. Team members worked in a purpose designed room where there were no distractions or interruptions. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It also had a locum pharmacist guide stored with SOPs which provided essential information to pharmacists unfamiliar with this pharmacy.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They had not recorded all near misses over the Christmas period. Team members were very experienced, and the pharmacist explained they were accurate dispensers. They discussed their mistakes but did not have formal reviews. They had separated various items in similar packaging. The superintendent pharmacist used a WhatsApp group to share pictures of similar packaging with all pharmacies in the group regardless of whether there had been errors with these or not. The team working in the hub also used near miss logs to identify and address errors made by the robot. Team members did not place certain products in the robot following incidents. They dispensed these into the compliance packs manually.

The pharmacy had a complaints procedure and welcomed feedback. Several people had commented positively about the new premises – the pharmacy had relocated several months before. Some people had commented that they could not come in easily due to two steps at the entrance. The pharmacy had installed a handrail to help address this. And team members suggested to people that they knock on the window and they helped him into the pharmacy. Sometimes they used a portable ramp which was easily accessible. The pharmacy had recently acquired planning permission to install a permanent ramp. The pharmacy had also received positive feedback from doctors and carers about photos the team supplied of the tablets in multi-compartment compliance packs. They had found this very useful if people were changing medication.

The pharmacy had an indemnity insurance certificate, expiring 02 May 20. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and

regularly audited; and a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read the company's privacy notice. The pharmacy had sent all team members a copy. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members were aware of potential safeguarding issues but had not completed any training on the topic. The pharmacy did not have local processes and contact details readily available. But team members knew these were available on the Internet.

Principle 2 - Staffing   ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. It provides work experience in different locations for team members to extend their knowledge. The pharmacy gives team members time to undertake essential reading to keep their skills up to date. Team members can share information and raise concerns to keep the pharmacy safe. They make suggestions to improve services.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time accuracy checking technician (ACT), three full-time and two part-time dispensers, and two part-time delivery drivers. Typically, there were two dispensers in the main pharmacy, and two dispensers and the ACT in the 'robot room'/hub working at most times. At the time of inspection there were two dispensers and a pharmacist in the main pharmacy. And one dispenser and the ACT in the hub. Team members were able to manage the workload.

The ACT spent one day per week in another branch undertaking all dispensing tasks to keep her other skills up, including the supply of over-the-counter (OTC) medicines and the delivery of substance misuse services. An ACT from another branch covered in the hub for her on that day. A dispenser who worked part-time in this pharmacy spent one day per week in another branch to undertake technician training. The pharmacy did not currently provide regular/routine time for training and learning in the pharmacy. But it provided time to read SOPs and other information as required. It was in the process of setting up performance development reviews for all team members. The pharmacy had paperwork that the pharmacy manager would issue to team members over coming weeks to help identify their learning needs.

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. They demonstrated 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. They could make suggestions and raise concerns to the manager or area manager. Examples were described of team members making suggestions to the pharmacy manager that had been adopted. These included the addition of additional shelving in the retail area as it was quite a large space. And discontinuing the use of drawers for commonly dispensed items, as team members did not routinely use these. Team members explained that they felt able to raise concerns with the pharmacy manager or with the superintendent pharmacist if necessary. The gave appropriate responses to scenarios posed. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. He did this using WhatsApp as described above. And sharing information informally with team members when he visited the pharmacy. He visited all the pharmacies in the group frequently. He had recently shared his concern about similar packaging of carbomer and chloramphenicol ophthalmic ointments. Team members shared information and discussed relevant topics such as medicines shortages during the working day

as there were quiet spells. This was observed. The ACT managed the robot room/hub, and shared relevant information with team members in this room. And she shared information with the pharmacist and pharmacy superintendent as required. The company held quarterly managers' meetings where a range of topics were discussed. The pharmacy did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and of a good standard for the services provided. The pharmacy has a bespoke design to provide the team members with separate areas of the premises for different activities. This promotes a safe way of working. Team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were spacious premises incorporating a retail area, dispensary, dispensing 'hub', and back shop area including storage space and staff facilities. The pharmacy had relocated to these premises several months previously. It had designed the premises to accommodate its services. The pharmacy team used the space well to separate different activities. The premises had a separate dispensing hub, with separate team members, and a dispensing robot to fill multi-compartment compliance packs for this and the other pharmacies in the company. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilets. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had put up a screen to replace a glass panel at the front of the dispensary as people could see in. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and team members help people to ensure that they can all access its services. The pharmacy provides services required by the local community. And it operates as a hub to supply some dispensed medicines safely to other pharmacies. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information and suitable advice to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had two steps, a hand-rail and an automatic door at the entrance. It had a portable ramp that team members sometimes used. And they helped people use the steps. They encouraged people to knock on the window if they needed assistance. The pharmacy listed its services and had leaflets available on a variety of topics. Its services included a full travel clinic which was well used by the local community. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

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. And they highlighted any changes or new medication to the pharmacist. 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 using a documented owings system.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. It had a separate 'hub' doing this for all the pharmacies (six) in the company. Dispensers in the pharmacies input information onto the patient medication record (PMR) but did not generate labels. Pharmacists in the different pharmacies entered the information onto the interface to the hub. They undertook clinical assessments at this stage. The pharmacists in the branches also checked packs when they were received by the pharmacy. A trained dispenser in the hub prepared the packs and generated backing sheets. After assembly in the robot, the dispenser carried out an accuracy check. They passed the packs to the ACT for a final accuracy check. She sealed the packs following her accuracy check. And she frequently used alcohol gel rub to ensure her hands were clean. The dispenser, ACT and pharmacist initialled the completed trays. The backing sheets had photographs of the tablets contained in the pack. Team members checked these were correct. If the pharmacy was using a different brand of tablets, sometimes the photo was wrong. Team members removed it from the system and reprinted the backing sheet. The ACT kept a list of these and the engineer who visited the pharmacy monthly added the correct ones. Tablets were stored in canisters in the robot, so team members had to remove tablets from blister packaging. They used a machine and placed the loose tablets in plastic containers. They labelled them with product name, batch number and expiry date. They also labelled containers with the date that tablets were removed from blister packaging, and team members' initials. Two team members were involved in this process to ensure accuracy. Team members explained the importance of this, and the potential implication of placing tablets in incorrectly labelled containers. They stored a maximum of one month's tablets like this. They did not store tablets loose

that were negatively affected by exposure to air, or not suitable for being placed in the robot. The robot sometimes damaged some small or unusually shaped tablets. It also sometimes made mistakes with some tablets or capsules leading to the incorrect quantities being placed into the pack. Team members dispensed these items into packs before the packs were placed into the robot. They kept a few shelves close to the robot for storing products that did not go into the robot. Team members had identified some of these products when carrying out accuracy checks of packs after the robot had filled them. They used near miss logs to record these. When different sized or shaped tablets were put into the robot team members had to change the canister lid to one with the correct size of opening. The pharmacy kept a large range of lids to enable team members to do this. Packs were usually dispensed and returned to pharmacies a week in advance of supply. The team operating the robot was very aware of timescales and always prioritised the most urgent. Team members normally left this pharmacy to last as delivery was not required. But packs were still ready several days before they were required. The pharmacy stored completed packs on dedicated shelves in the dispensary, separated depending on whether they were collected or delivered. Team members used a system of moving packs onto different shelves each week to help identify when prescriptions needed to be ordered. They kept records of changes, hospital discharges and any other intervention or communication. And they supplied patient information leaflets with the first pack of each prescription. Team members printed these from the electronic medicines compendium website when required. The pharmacy supplied a range of other medicines by instalment. A team member dispensed these as people presented at the pharmacy. But this process was being reviewed with a view to dispensing these in advance to ensure they were ready when people arrived at the pharmacy.

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 had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chlamydia treatment. It also followed private PGDs for flu and travel vaccinations. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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.

The pharmacist provided a full travel service including yellow fever vaccination. She was trained and competent. She had successfully completed training several months previously when the pharmacy had relocated to this premises. All team members were trained to promote and explain the service to people. When people asked about the service a team member gave them an assessment form to compete with personal details, relevant medical history and travel intentions. The pharmacist reviewed this and usually phoned or emailed patients to arrange an appointment. She took time to fully assess the request using reputable professional websites such as 'Travax'. She told people what her recommendation was depending on their situation and told them the cost before the appointment. She also used the Travax website to show people the risk of different diseases in different areas. The pharmacist delivered the smoking cessation service, but it was not well used in this pharmacy.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures and took appropriate action taken if there was any deviation from accepted limits. They 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 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 for the delivery of its services. The pharmacy looks after this equipment to ensure it works. Pharmacy team members raise concerns and discuss issues with the appropriate people if they equipment is not working properly.

Inspector's evidence

The pharmacy had texts 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 sundries, sharps bins and emergency adrenaline required for vaccination. Team members used alcohol gel rub, gloves and antiseptic wipes for infection control. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were available for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy used automatic equipment including a dispensing robot to assemble multi-compartment compliance packs. It had a maintenance contract that included a monthly visit from an engineer who serviced and cleaned the machine to ensure it worked safely. Team members were aware that a build-up of tablet dust could affect its efficiency. They contacted the engineer if they had any concerns or required advice about the robot. The pharmacy also had equipment to remove tablets from blister packaging which was maintained in line with the manufacturer's guidance. Team members used labelled plastic containers to store tablets that had been assessed as suitable for storage in this way. And they had plenty of canisters for use in the robot, including a range of different lids to be used with canisters, depending on tablet size and shape. The team member responsible for managing this process described how the team stored and cleaned equipment and used it in line with the manufacturer's guidance. She coached other team members new to this area to ensure that they used the equipment correctly.

The pharmacy stored paper records in cupboards in the consultation room inaccessible to the public. Team members stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. They used passwords to access computers and never left 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.