General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Omnicare Pharmacy Ltd, 160 Causewayside, Edinburgh, Midlothian, EH9 1PR

Pharmacy reference: 9011218

Type of pharmacy: Community

Date of inspection: 09/01/2024

Pharmacy context

This is a community pharmacy in a predominantly residential area of Edinburgh. Its main services include dispensing of NHS prescriptions, and it dispenses medicines in multi-compartment compliance packs to help people take them properly. Team members advise on minor ailments and medicines use. And the pharmacy supplies medicines to people living in local care homes. The pharmacist conducts travel consultations and administers vaccinations.

Overall inspection outcome

✔ Standards met

Required Action: None

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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 mostly 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 comprehensive electronic set of standard operating procedures (SOPs) to help team members manage risks. The SOPs had been recently transferred to an electronic platform. And team members were in the process of reading the updated SOPs relevant to their roles. 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 an electronic record. They explained errors were highlighted to them by the pharmacist, and the team member 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 errors which looked alike, or names sounded alike (LASA), for example trazodone and tramadol. The team had separated the medicines to reduce 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 on an electronic platform and were then reviewed by the superintendent pharmacist (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 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 generally compliant but there were some missed sign-out entries on the record observed. 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 each dispensing and on receipt of CDs. And this was recorded on the register. The pharmacist advised that they checked the balance of all CDs on a weekly basis but this was not recorded on the electronic register so there was no audit trail to confirm completion. 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 company privacy notice and an NHS Pharmacy First privacy notice were 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 waste bags for uplift and destruction by a third-party contractor. The pharmacy stored confidential information in staff-only areas. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. And they had access to contact details to

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 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 manager who had recently qualified as an independent prescriber. Other team members included a full-time dispenser, a part-time dispenser and a newly employed part-time trainee dispenser. A full-time accuracy checking technician (ACT) managed operations relating to dispensing multi-compartment compliance packs. There were also two full-time dispensers who worked in this area. The team were observed working well together and managing the workload. Planned leave requests were managed so that only one team member was absent at a time. Team members were able to rotate tasks so that all tasks could be completed effectively during absence periods. Part-time staff members were also used to help cover absences. And relief dispenser support was available to be requested from head office.

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. The newly employed trainee dispenser completed a company induction with members of the head office team. They completed the company mandatory e-learning and read the company policies and procedures. And they shadowed other team members. The pharmacist had informal meetings with all staff members where they discussed any learnings from near misses or dispensing incidents and recent drug alerts. The team felt comfortable to raise any concerns to their pharmacist or SI and a whistleblowing policy was in place. They received bi-annual formal appraisals with the pharmacist where they had the opportunity to identify individual learning needs. And these were documented. There were no targets set for some 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 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.

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 private consultation facilities where people can have confidential conversations with a pharmacy team member if needed.

Inspector's evidence

The premises were secure and provided a professional image. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. There was a dispensing area in the rear of the pharmacy that was mainly used to dispense multi-compartment compliance packs as a hub pharmacy for other pharmacies owned by the same company. A bench used by the RP to complete the final checking process was at the side 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. A good-sized consultation room was clearly signposted and had lockable storage for confidential information. And there was an additional consultation and treatment room used by an external company to provide chiropractor services.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. And team members regularly cleaned pharmacy workspaces and staff facilities. The pharmacy kept heating and lighting to an appropriate level in the dispensary and retail area.

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 easily accessible to people. The pharmacy receives its medicines from reputable sources and stores them appropriately. The team carries out checks to help ensure the medicines are kept in good condition.

Inspector's evidence

The pharmacy had good physical access with a level entrance and a manual door 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 leaflets for people to read or take away, these included information on NHS Pharmacy First Service and Covid-19.

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. The baskets were stored on a separate bench whilst waiting to be checked by the pharmacist. This enabled the dispensary benches to remain clear. Team members signed dispensing labels to maintain an audit trail. The pharmacy offered a delivery service and kept records of completed deliveries, including CDs.

Team members demonstrated an awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And they were aware of the most recent patient safety alert relating to valproate. The team explained that they did not have any patients who were in the at-risk group prescribed valproate.

The pharmacy provided multi-compartment compliance packs to several people to help them take their medication correctly. And it provided the service as a hub dispensary for the other pharmacies in the company, known as the spoke pharmacy. A dedicated team member in the main dispensary managed this process. They used medication record cards that contained each person's medication and dosage times. And they ordered peoples repeat prescriptions and reconciled these against the medication record card. 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 for assembly using the automated dispensing machine. And the hub was provided with the physical copy of the prescription and the medication record card to facilitate an accuracy check of the completed multi-compartment compliance pack. The ACT advised that all the spoke pharmacies followed the same process. A 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 by the spoke pharmacies, so people had access to up-to-date information about their medicines.

The medicines stock for the automated dispensing machine was de-blistered and placed into canisters. Each canister contained the same bath number and expiry dates so that there were no mixed batches. The dispenser applied a label to each canister detailing the batch number and expiry date, the date the medicine was put into the canister, and they signed the label to confirm the person responsible for dispensing the medicine into the canister. An ACT performed a second check before the canisters were

authorised to be loaded into the dispensing machine and they signed the dispensing label to confirm the accuracy check. The team kept an additional paper record of all batch number and expiry dates of stock in the canisters so that medicines could be identified in the event of a product recall. The team used barcodes to manage medicines not stored in the dispensing machine which were added to multi-compartment compliance packs. Barcodes from the medicines stock boxes were scanned before addition to the packs as an additional accuracy check.

The pharmacy supplied medicines in their original packs to people living in ten local care homes. And it provided accompanying medication administration records. The care homes were responsible for ordering the medicines for people living within the homes and the pharmacy team reconciled the prescriptions against the order requests on receipt of the prescriptions. The company care home manager visited the home regularly to complete an audit of the service provided.

The regular pharmacist provided a private vaccination service including travel vaccinations and childhood immunisations. They had completed face-to-face vaccination training, basic life support training and an online training module prior to providing the service. And they had read the patient group directions (PGD). The service was managed via an appointment schedule.

The pharmacy obtained its stock medicines from licensed wholesalers and stored them on shelves and in drawers. Team members had a monthly process for checking expiry dates of the pharmacy's medicines. Short-dated stock which was due to expire soon was highlighted and rotated to the front of the shelf, so it would be used first. The team advised that they were up to date with the process and kept a record of checks they had completed. The team marked liquid medication packs with the date of opening to ensure they remained suitable to supply. A random selection of medicines were checked and no out-of-date medicines were found to be present. The pharmacy had a medical grade fridge to store medicines that required cold storage and it 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 accepted range of two and eight degrees Celsius. The pharmacy received medicine alerts electronically through email. The team actioned the alerts and kept a printed record of the action taken. They returned items received damaged or faulty to manufacturers as soon as possible.

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

Team members had access to up-to-date reference sources including the British National Formulary (BNF), and the BNF for children. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. The automated dispensing machine for multi-compartment compliance packs was serviced every three months by the external provider. And engineer support was available via telephone for the machine.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area 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.