General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Omnicare Pharmacy, 1 Ardmillan Terrace, Edinburgh, Midlothian, EH11 2JN

Pharmacy reference: 9011847

Type of pharmacy: Community

Date of inspection: 21/08/2023

Pharmacy context

The pharmacy had recently relocated to larger premises on a high street in a residential area in the city of Edinburgh. Its main services include dispensing of NHS prescriptions, and it dispenses some medicines in multi-compartment compliance packs to help people take their medicines. Team members advise on minor ailments, and they deliver the NHS Pharmacy First service.

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 responsible pharmacist record entries are not made in accordance with regulatory requirements.
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 accurately maintain all records it must by law, so it cannot always show that it is operating safely and effectively. It has a complete set of written procedures that have been reviewed but team members have not read these so they may not carry out tasks consistently and safely. Pharmacy team members take some steps to learn from things that go wrong. But they do not review records of their mistakes. So, some learning opportunities may be missed. Team members keep people's confidential information secure. And they have the knowledge they need to help protect vulnerable people.

Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) that had been reviewed in March 2023. There were training records relating to the previous set of SOPs which some members of the team had signed in 2018 to confirm they had read and understood them. But team members were unaware that SOPs had been updated and confirmed they had not yet read the newer version. 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. But at times they were completing tasks such as labelling and assembly of medicines that should only be completed in the prescence of an RP.

Pharmacy team members had access to an electronic near miss log to record any mistakes they identified during the dispensing process. They also had access to an electronic dispensing incident log to record details of any errors which were identified after the person had received their medicines. They explained errors were highlighted to them by the pharmacist, and it was then their responsibility to enter it onto the record. This allowed them to reflect on the mistake. Team members had implemented changes to help prevent the risk of errors happening. They had separated some products that looked alike and sounded alike. This included separating stock packs of prednisolone and propranolol. There was no formal review of near misses or dispensing incidents so team members may miss opportunities to learn from these errors. The pharmacy had a complaints policy and the team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the SI. The operations manager had visited the pharmacy to review compliance with pharmacy procedures. There were some follow up actions for the team to complete. This included ensuring that the temperature of the medicine's fridge was checked and recorded daily which had been actioned by the team.

The pharmacy had current professional 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 log contained erroneous entries that indicated that the superintendent pharmacist (SI) had been acting as RP for periods of time when he had not. The team explained that this had happened because the pharmacy computer could not operate until an RP was signed in. So in the mornings, a team member signed in as the SI in order to access the patient medication record to print dispensing labels and sometimes assemble medicines in the absence of an RP. This meant the record was inaccurate and could cause uncertainty about who was responsible at specific times. The SI was unaware that dispesning activities were taking place and gave assurance that the activity would cease. The controlled drug (CD) register was held electronically, and it appeared to be in order. Running balances were recorded and checked against the physical stock levels of CDs every month. A record of patient returned CDs was maintained

in an electronic register and this was up to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were recorded to provide an audit trail. Accurate electronic records of private prescriptions were maintained.

An NHS Pharmacy First privacy notice and a company privacy notice were displayed in the retail area explaining how the pharmacy handled personal information. Team members were aware of the need to keep people's information confidential. The pharmacy kept sensitive information and materials in restricted areas away from unauthorised access. It collected confidential waste in dedicated bags which were collected periodically by a third-party contractor for secure destruction. Pharmacy team members had completed some learning associated with their role in protecting vulnerable people. They were familiar with common signs of abuse and neglect. And they understood their obligations to manage safeguarding concerns. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage its workload. It supports its team members to keep their knowledge and skills up to date. Team members understand how to raise a professional concern if required.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager. They were supported by a full-time technician, who was the dispensary lead, two part-time technicians and a trainee dispenser. The SI and the operations manager also visited the pharmacy regularly and worked as RPs on occasion. The trainee dispenser had recently been enrolled on an accredited training course. The team were observed working well together and managing the workload. Planned leave requests were managed so that only a few team members were 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 pharmacist and technician had recently attended face to face training for delivery of an NHS Nasal Naloxone service and they were observed when delivering the service as part of the sign off process. 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 targets set for some pharmacy services but team members did not feel under pressure to achieve them.

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. And they would refer to the patient medication record to support some sales of medicines. Team members explained that they had received some requests for codeine linctus and that they reported this to the pharmacist. 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 pharmacy maintains them to a high standard. It has private consultation rooms and other suitable facilities where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy had recently moved to new premises that were secure and maintained to a high standard. It was clean and organised throughout. The pharmacy workspace was well organised with designated areas for completion of pharmacy tasks and suitable storage of prescriptions. There was a separate centrally positioned bench used by the RP to complete the final checking process. And there was an area to the rear of the pharmacy to dispense medicines into multi-compartment compliance packs. The pharmacy was cleaned and there was a rota showing when this had been completed. The medicines counter could be clearly seen from the dispensary which enabled the pharmacist to intervene in a sale when necessary. Two good- sized consultation room were suitably equipped and fit for purpose. These spaces allowed team members to have private conversations with people. And they had locked storage cupboards to prevent unauthorised access to confidential information and equipment when not in use. Team members used a hatch between the dispensary and retail area that was protected by a screen to provide supervision of substance misuse services and a needle exchange service.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. The pharmacy kept heating and lighting to appropriate levels in the dispensary and retail area. There were chairs in the retail area that provided a suitable waiting area for people receiving clinical services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. It manages it 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 a level entrance with an automatic door. It displayed its opening hours and pharmacy services on the exterior of the premises. The team also kept a range of healthcare information leaflets for people to read or take away. These included information on the NHS Pharmacy First Service. The pharmacy had some healthcare information posters for people to read.

Team members demonstrated an awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They explained how they would highlight any prescriptions for valproate for the attention of the RP. They knew to apply dispensing labels to the packs in a way that prevented the written warnings on the packs from being covered up. But trainee team members were not aware of the requirements. Team members used various alert stickers to attach to prescriptions for people’s dispensed medicines. They used these as a prompt before they handed out medicines which may require further intervention from the pharmacist.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. 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. The baskets were colour coded to enable team members to identify the type of prescription stored within and to manage workload. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed and checked the medicine. The pharmacy gave owing slips to people when it could not supply the full quantity of medicines prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. And there was an additional record of CD deliveries where the delivery driver obtained people’s signature to confirm receipt.

A large proportion of the pharmacy’s workload involved supplying medicines in multi-compartment compliance packs to help people manage them better. These were dispensed at an offsite dispensing hub pharmacy. 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 reconciled these against the medication record sheet. They documented any changes to people’s medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The prescriptions were clinically checked by the pharmacist at the pharmacy, and this was confirmed with a stamp. The information from the prescription was inputted into the system and accuracy checked in the pharmacy, then it was sent through to the offsite hub pharmacy so that the compliance aid could be dispensed. The packs were annotated with detailed descriptions which allowed people to distinguish between the medicines within them. The pharmacy supplied people with patient information leaflets, so they had access to up-to-date information about their medicines.

Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The prescriptions were stored according to the date they were due. This allowed the team to dispense medicines in advance of people collecting and to manage requests for non-repeat medicines. The NHS Pharmacy first service was popular. This involved supplying medicines for common clinical conditions. Team members had developed a consultation record form where they recorded the persons details, symptoms, and the prescribed product, to use as a prompt to enter onto the patient medication record (PMR). The NHS Pharmacy First service also involved prescribing under a patient group direction (PGD) for some prescription only medicines such as trimethoprim for urinary tract infections. The pharmacist could access the PGDs electronically and also had paper-based copies. And they retained a copy of the consultation record form.

The pharmacy obtained its stock medicines from licensed wholesalers and stored them tidily on shelves. Team members had a 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 was selected first. The team advised that they were up to date with the process and a date checking log was completed by team members to demonstrate when checks had been done. A random selection of medicines were checked and no out-of-date medicines were found to be present. The team marked liquid medication packs with the date of opening to ensure they remained suitable to supply. The pharmacy had medical grade fridges to store medicines that required cold storage. The team recorded daily checks of the maximum and minimum temperatures. A sample of the records seen showed the fridge was operating within the correct range of between two and eight degrees Celsius. The pharmacy received notifications of drug alerts and recalls via email. And team members carried out the necessary checks and knew to remove and quarantine affected stock. The pharmacy had medical waste bins and CD denaturing kits to manage 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

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. And it had a set of clean, well-maintained tablet and capsule counters. Team members used an automated measuring machine for the dispensing of some CD liquids that was calibrated before use and regularly cleaned. And it documented these tasks were completed on an electronic log.

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.