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: 08/04/2024

Pharmacy context

This is a pharmacy in a residential area of Edinburgh. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicine correctly. It supervises the administration of medicines to some people as part of a substance misuse service. And it delivers medicines to people in their homes.

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 always maintain accurate responsible pharmacist records. This is similar to the previous inspection.
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 required by law, so it cannot always show it operates safely and effectively. Team members make some records of mistakes, and they make some changes to help prevent the same or a similar mistake occurring. Team members keep people's private information secure and respond appropriately to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were kept electronically. These included SOPs about controlled drug management, date checking and the responsible pharmacist (RP). And team members had signed to say they had read them, but a recent SOP about working in the absence of a RP had not been read by current team members.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. Records showed that the pharmacy had recorded on average one near miss per month from November 2023 and before this the last records were in June 2023. The details were recorded by the person who made the mistake so they could learn from them. Following near misses, team members had separated medicines on the dispensary shelves to help reduce the risk of selection mistakes. This included prednisolone and propranolol. They didn't analyse near misses for trends in mistakes to further reduce the risk of mistakes. The pharmacy completed incident reports for mistakes that were identified after a person had received their medicine, known as dispensing errors. These were recorded on the pharmacy's patient medication record (PMR) and the pharmacist was unsure if the details of the error were shared with the pharmacy's superintendent (SI) pharmacist. They were unaware of how to access previous incident reports and so the quality of records could not be assessed during the inspection. The pharmacy had a complaints procedure displayed in the retail area of the pharmacy. Team members aimed to resolve any complaints themselves informally and if they were unable to, they provided people with the contact details for the SI.

The pharmacy had current professional indemnity insurance. The RP notice was prominently displayed in the retail area of the pharmacy and reflected the details of the pharmacist on duty during the inspection. The RP record was not always accurate, as on occasions an electronic entry was made by a pharmacy team member prior to the arrival of the pharmacist. The RP was sometimes unaware that they had been signed in in this way until they arrived at the pharmacy to assume RP responsibilities. There had been a similar issue identified at the last inspection. An SOP has been introduced following the previous inspection, but current team members had not read it. The pharmacy had electronic CD registers. Team members checked the physical stock levels of CDs matched those in the CD register when the supply of the medicine was recorded. This meant medicines that were not supplied frequently were not checked regularly. For example, a less frequently supplied medicine was last checked in November 2023. The pharmacy kept a record of medicines supplied against private prescriptions and kept the associated prescriptions. It kept a record of the supplies of unlicensed medicines, including who received the medicine so an audit trail was maintained.

The pharmacy displayed an NHS data processing notice in the retail area informing people of how their private information was used. Team members were aware of their responsibility to keep people's

private information secure. And they separated confidential waste for destruction by a third-party company. Team members knew to report any concerns about vulnerable people accessing the pharmacy's services to the pharmacist. The pharmacist and trainee pharmacist were registered with the Protecting Vulnerable Groups scheme and the pharmacist knew who to contact in the event of any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified and team members in training to help manage its workload safely. Team members in training receive appropriate supervision and support to complete their qualification training courses. Pharmacy team members ask suitable questions when assisting people with their healthcare needs. And they feel comfortable to raise professional concerns if necessary.

Inspector's evidence

The RP was an employed full-time pharmacist. They were supported by a pharmacy technician, a trainee pharmacist, a newly employed trained dispenser and a trainee dispenser. Another trained dispenser was not present during the inspection. And a new team member was undergoing induction at the company's head office before starting work at the pharmacy. There was also a delivery driver. The trainee dispenser's training had been overseen by a pharmacy technician, and this was in the process of changing to the pharmacist. The trainee dispenser completed training at work during quieter periods or out with business hours at home if needed. The trainee pharmacist received protected learning days and study days to support their training year. Team members completed ongoing training to develop their knowledge and skills. They had recently been trained to take people's blood pressure.

Team members were observed working well together, they were managing the workload and supported each other with queries. The trainee pharmacist helped people with queries and knew to refer anything they were unsure about to the pharmacist. Team members felt comfortable to raise professional concerns with the SI if required. They received performance reviews bi-annually with the last completed in November 2023. The pharmacy set its team members targets and they did not feel under pressure to achieve them.

Team members asked people appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse such as codeine-containing medicines. Team members referred such requests to the pharmacist who would have supportive conversations with people and refer them to their GP if necessary. They also knew to be vigilant to repeated requests for prescribed medicines and contacted the GP to highlight any concerns, but did not always keep records of these interventions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are secure, clean and suitable for the services it provides. It has suitable facilities for those requiring privacy when accessing the pharmacy’s services.

Inspector's evidence

The pharmacy’s premises were comprised of a large retail space to the front and dispensary to the rear. It had a medicines counter which acted as a barrier and prevented unauthorised access to the dispensary. The dispensary was spacious, with a good workflow and different benches for the completion of different tasks. This included a separate area for the preparation or multi-compartment compliance packs. The pharmacist’s checking bench was situated centrally in the dispensary which allowed for effective supervision of the dispensary and ability to intervene in conversations at the medicines counter if necessary. The pharmacy was cleaned according to a rota, and this was up to date. The pharmacy had a sink for handwashing and professional use. There was a toilet which provided separate facilities for handwashing. The temperature was comfortable throughout and the lighting was bright.

The pharmacy had two consultation rooms where people could have private conversations with team members and access services from the pharmacist. The rooms had a desk and chairs and one of the consultation rooms had a sink with provided hot and cold water. However, the sink looked dirty. A separate room was used for the supervision of medicines for the substance misuse service. Access to the room was managed by team members in the dispensary and medicines were supervised at a hatch which was secured when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages and delivers its services safely and effectively. It sources its medicines from recognised sources. And it mainly manages its medicines as it should. Team members complete suitable checks to ensure medicines remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street which provided ease of access for those using wheelchairs and prams. Team members could provide large print labels for people if needed. But only the name of the medicine was enlarged and not the directions which may make it difficult for people to know how to take their medicines. Team members explained they would counsel people about how to take their medicines. Team members also provided some people with hearing difficulties information about their medicines in writing. Some team members spoke additional languages to English, which helped people who did not speak English as their first language.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed-up. They did not always sign dispensing labels to confirm who had dispensed the medicine, so an accurate audit trail was not always kept. The pharmacist confirmed he encouraged team members to sign the dispensing labels. Stickers were used which indicated the inclusion of a fridge line, CD, delivery or if referral to the pharmacist was required when the medicine was handed out. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. Team members were observed making suitable checks when handing out prescriptions to ensure they were given to the correct person. They supplied people with an owing slip, which was a record of medicines they could not provide the full quantity of. They gave people the opportunity to access medicines elsewhere or arranged an alternative with the person's GP if medicines were not available.

The pharmacy supervised the administration of medicine to some people using an automated dispensing machine. Team members prepared the medicine ahead of time rather than dispensing it when people presented at the pharmacy. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicine correctly. Team members ordered prescriptions in advance so that any queries with a person's medication could be resolved. Each person had a medication record which detailed the medicines taken and dosage times. The packs were dispensed using automation at another pharmacy in the company. Team members sent the details of the prescriptions electronically and sent the paper copy of people's medication record with the delivery driver. The paper copies were signed to say a clinical check had been completed by the pharmacist. Accuracy checking pharmacy technicians working at the other pharmacy completed the final accuracy check before returning the packs to the pharmacy. Changes to people's medication were communicated from the GP using a medication change sheet. The pharmacy team updated the person's medication record and the pharmacist completed a new clinical check. Descriptions of the medicines in the pack were provided so that they could be identified. The pharmacy provided patient information leaflets when a person's pack was supplied for the first time and when a new medicine issued. This may mean people don't have the most up-to-date information about the medicines they take.

The pharmacy provided a delivery service, taking medicines to people in their homes. The driver asked people to sign for the receipt of their CDs. The driver had been delivering to the same people for many years and had developed good relationships with them. He explained he sometimes took decisions to leave medicines through letterboxes for people who were not available to receive them. Some risk had been considered and no CDs or fridge lines were left unattended. The SI subsequently confirmed they had recently updated the delivery policy to allow medicines to be posted in this way after documented consent from people was given. Examples of consent were not seen during the inspection.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which help ensure the sale of these medicines were supervised by the pharmacist. Team members checked the expiry dates of medicines during quieter periods. The last recorded checks showed two different sections had been completed in March 2024. Medicines that were going out of date in six months were highlighted for use first. A random selection of 15 medicines found none were out of date but one was short dated and not highlighted. The pharmacy had two fridges, one in the main dispensary and one for the storage of covid vaccinations in a consultation room. Team members recorded the fridge temperatures of the main fridge. Records were only available for April but showed that the fridge was operating between the required two and eight degrees Celsius. There were no current records for the vaccination fridge, but the pharmacist confirmed the service was no longer being provided and the vaccines were due to be disposed of. Team members received notifications about drug alerts and recalls via email. These were printed and actioned by team members.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had a blood pressure machine to check people's blood pressure, but it was not marked with the date of first use or when it had last been calibrated. Measuring cylinders used for measuring liquids were available and were British Standard or crown marked to show they measured accurate volumes. The cylinders used for water and liquid medicines were marked to show which were for water and which were for liquid medicines. And cylinders used for medicines provided in the substance misuse service were kept in a separate area of the pharmacy where there was also an automated machine which was used to prepare doses. The pharmacist calibrated the machine each day to ensure volumes poured were accurate.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords. Screens were positioned in the dispensary and behind the medicines counter in a way that prevented unauthorised access to confidential information.

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.