General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Omnicare Pharmacy, 25 Main Street, Mid Calder, Livingston, West Lothian, EH53 0AW

Pharmacy reference: 9011919

Type of pharmacy: Community

Date of inspection: 26/09/2023

Pharmacy context

This is a newly opened community pharmacy in the village of Mid Calder in Lothian. Its main services include dispensing of NHS prescriptions, and it dispenses medicines in multi-compartment compliance packs to help people take them properly. And it delivers medicines to people living in local care homes. Team members advise on minor ailments and medicines use. And they deliver the NHS Pharmacy First Service.

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. Its complete set of written procedures 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 comprehensive set standard operating procedures (SOPs) to help team members manage risks. And these had been recently reviewed by the superintendent pharmacist (SI) in 2022. Team members read the SOPs relevant to their roles and signed record of competence to confirm their understanding of them. 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 it was then their responsibility to enter it onto the record. This allowed them to reflect on the mistake. Team members each had their own near miss record to improve accountability in recording their errors. The pharmacist reviewed the records regularly to identify trends and patterns. Following a recent incident involving the incorrect formulation of a medicine being supplied, the different formulations had been segregated in the medicines storage drawers to reduce the risk of the incident happening again. The team also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. A poster requesting feedback on pharmacy services was displayed in the retail area. Members of the team aimed to resolve any complaints or concerns informally. But if they were not able to resolve a complaint, they would escalate to the pharmacist manager or SI. A support manager from head office had recently visited the pharmacy to review compliance with pharmacy procedures. There were some follow up actions for the team to complete. Fpr example the team had completed an action point that all SOPs read by team members must have an accompanying record of competence.

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. And the RP record was up to date. 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 every time a CD was dispensed and or received. There was a paper record of patient returned CDs and this was up to date. Appropriate records of private prescriptions were maintained. Certificates of conformity for unlicensed medicines were held and full details of the supplies were recorded to provide an audit trail.

A 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 information confidential. They were observed separating confidential waste in dedicated bags which were collected periodically by a specialist contractor for secure destruction. The pharmacy stored confidential information in staff-only areas and in secure locked cupboards within the consultation

room. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. And they knew to discuss any concerns with the pharmacist and had access to contact details for 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 enough team members with the right qualifications and knowledge to manage its workload and provide its services effectively. Team members complete appropriate training for their roles and keep their skills up to date. They work well together and communicate effectively. And they are comfortable raising concerns and identifying individual learning needs.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager. There was a full-time and a part-time dispenser and two part-time trainee dispensers. A trainee foundation pharmacist was also working at the pharmacy. Team members had all completed accredited training or were enrolled on an accredited training course for their role. They were observed working well together and managing the workload. The pharmacy's workload had continued to increase steadily since opening and the pharmacist felt that the staffing levels were appropriate for the current workload volume. Planned leave requests were managed so that only one key staff member was off at a time. Part-time staff members were also used to help cover absences.

Team members who were enrolled on an accredited training course received protected learning time. Their training had included reading SOPs and topics such as safeguarding. Team members completed some ongoing training relevant to their roles during quieter periods within the pharmacy. The pharmacist had recently held a training session with the team on over-the-counter medicines that may be liable to misuse and this included a review of the medicine sales protocol. They 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 the pharmacist, owners, and SI. Each member of the team received a formal appraisal with the pharmacist where they had the opportunity to raise any individual learning needs. Recently team members had asked for more support with dispensing of medicines for the care home. The pharmacist arranged for the care home managers to work in the pharmacy as additional support for the team. There were no targets set for 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 subject to misuse, for example codeine containing medicines. And they would refer such requests to the RP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the team maintain them to a high standard. It has private consultation room and advice area where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The premises were secure, modern, and presented a professional image. The pharmacy workspaces were very well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. The main dispensary had a separate area at the rear where team members could work if required to reduce distractions. This was mainly used to dispense multi-compartment compliance packs and to dispense medicines for the care home. A bench used by the RP to complete the final checking process was located at the side of the 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 could be accessed from the retail area and the dispensary. And there was also a pharmacy advice counter to allow people to have more private conversations with team members.

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 an appropriate level in the dispensary and retail area. There were chairs in the retail area that provided a suitable waiting area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers services that are well managed and easy for people to access. It receives its medicines from licensed wholesalers and stores them appropriately. The team carries out checks to help ensure medicines are kept in good condition and safe to supply.

Inspector's evidence

The pharmacy had ramped access with a manual door. It displayed its opening hours and pharmacy services in the window. It had an information leaflet which provided people with details of the repeat prescription services it offered and the contact details of the pharmacy. The team also kept a range of healthcare information leaflets for people to read or take away.

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 shelving 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 team provided owing's slips to people when it could not supply the full quantity prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine. The pharmacy offered a delivery service and kept records of completed deliveries, including CDs.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. The pharmacist explained team members 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. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack.

A large proportion of the pharmacy's workload involved supplying some people's medicines in multi-compartment compliance packs. This helped people better manage their medicines. 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 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 packs were annotated with detailed descriptions which allowed people to distinguish between the medicines within them. The pharmacy did not routinely supply people with patient information leaflets, so they may not have access to up-to-date information about their medicines. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process. Most of the compliance packs were dispensed at an offsite dispensing hub. The prescriptions were clinically checked by the pharmacist at the pharmacy, and this was confirmed with a stamp. The prescription and medication record sheets were sent to the hub who completed the dispensing process.

The pharmacy supplied medicines in their original packs to people living in four local care homes. And it provided accompanying electronic medication administration records. The care home manager visited

the home regularly to complete an audit of the service provided. Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The prescriptions were stored alphabetically, and people telephoned the pharmacy to advise that they required their next prescription supply. This allowed the team to dispense medicines in advance of people collecting. The NHS Pharmacy first service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD). The pharmacist could access the PGDs electronically and had paper-based copies.

The pharmacy obtained its stock medicines from licensed wholesalers and stored them on shelves and in drawers. 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 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. 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. Its equipment is 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. Dispensed medicines awaiting collection were stored 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. The pharmacy had cordless telephones and team members were observed moving to a quieter area of the pharmacy 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.