General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fleming Pharmacy, 1 Liberton Drive, Edinburgh, Midlothian, EH16 6NL

Pharmacy reference: 9011956

Type of pharmacy: Community

Date of inspection: 16/08/2023

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. The pharmacy has a 24-hour collection point which allows people to collect their dispensed medicines at any time, including outside of the pharmacy's opening hours.

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	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 suitably manages risk to help team members provide safe services. And they keep the records that are needed by law. They keep people's private information safe. And they know what to do to help protect the health of vulnerable people. They discuss mistakes they make when dispensing so that they can learn from them. But they do not regularly record these mistakes so they may miss some opportunities to improve the way they work.

Inspector's evidence

The pharmacy had a comprehensive set standard operating procedures (SOPs) to help team members manage risks. And these were currently being reviewed by the superintendent pharmacist (SI). Team members read the SOPs relevant to their role and completed a record of competence signature sheet 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.

Since the pharmacy had moved to its new premises, the pharmacy team had not recorded any near misses, which were errors identified before the person received their medicines. But all team members confirmed that they still discussed errors with the pharmacist when they happened and implemented changes to reduce the risk of the same error occurring. This included a recent error involving allopurinol and amlodipine being mixed up. Team members had separated the products on the storage shelves and alerted the rest of the team. There had been no formal review of near misses so team members may miss opportunities to learn from them. The pharmacy had a process for recording dispensing incidents, which are errors identified after the person has received their medicines. The incidents were recorded on the patient medication record (PMR) and reviewed by the SI. 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 it to the SI. An electronic tablet device had recently been installed in the retail area for people to provide feedback and to rate their experience of pharmacy services. And the feedback was reviewed. Feedback they had received included praise for customer service and timeliness of the prescription collection service.

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 record was generally weel maintained but there were some occasions when the RP had not recorded the end of their tenure. This meant that the pharmacy may not always be able to show who was responsible at a specific point in time. Controlled drug (CD) registers appeared to be in order. Running balances were recorded and checks were completed monthly. This helped to identify any issues such as missed entries. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept appropriate records of CDs returned to the pharmacy. And it held certificates of conformity for unlicensed medicines and full details of the supplies were recorded to provide an audit trail. Records of private prescriptions were up to date.

Team members were aware of the need to keep people’s private information secure. They were observed separating and shredding confidential waste. The pharmacy stored confidential information in staff-only areas. Pharmacy team members had completed learning associated with their role in

protecting vulnerable people. They understood their obligations to manage safeguarding concerns and were familiar with common signs of abuse and neglect. They knew to discuss their concerns with the pharmacist and had access to contact details for relevant local agencies. The pharmacists were members of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient team members to manage its workload and provide its services safely and effectively. And it supports them to keep their skills and knowledge up to date. Team members have the right qualifications for their role. They work well together and communicate effectively. And they are comfortable providing feedback and suggesting improvements.

Inspector's evidence

The superintendent pharmacist was working as the RP and worked in the pharmacy regularly. There was also a second pharmacist that worked part-time who was currently completing their Independent Prescribing Qualification. There was a large pharmacy team including three pharmacy technicians, one of whom was employed as an accuracy checking technician (ACT). 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 workload had continued to steadily increase since moving premises and since a nearby pharmacy had closed. Staffing levels were currently being reviewed by the SI and an additional staffing vacancy was being created. 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.

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 role during quieter periods within the pharmacy. And they completed some of this training via an online learning platform. The SI had recently held a training session with the team on over-the-counter medicines that may be liable to misuse. 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 SI and pharmacist. And they felt comfortable to actively share improvement ideas to the pharmacist. Recently team members had suggested and implemented a new prescription storage solution to help manage the increased volume of prescriptions. And they had suggested and rearranged the location of medicines to improve the efficiency of the dispensing process. They did not have formal appraisal meetings, but they received regular feedback as they worked.

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 from people for medicines subject to misuse, for example, codeine containing medicines. And that they would refer them to the pharmacist. There were no targets set for pharmacy services.

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 rooms where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The premises were secure, modern, and provided a professional image. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. The main dispensary had a separate area where team members could work if required to reduce distractions. This was mainly used to dispense multi-compartment compliance packs. 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. The dispensary area was accessed via a door from the retail area which was kept locked to prevent unauthorised access. Two good-sized consultation rooms were clearly signposted and able to be locked when not in use.

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 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 both stepped and ramped access with a handrail and 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 depression and anxiety. There was access to a hearing loop for people with a hearing impairment.

The pharmacy provided separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to safely store medicines and prescriptions throughout the dispensing process. And larger trays were used for multi-compartment compliance pack prescriptions. This helped manage the risk of medicines becoming mixed-up. 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 did not routinely provide owing slips to people when it could not supply the full quantity of medicines prescribed. So people did not have any evidence to remind them what they were owed. But the team advised people at the point of collection if there was an owing. The pharmacy offered a delivery service and kept records of completed deliveries.

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 avoided covering up the written warnings on them. The RP was aware that they had people who had been prescribed valproate who were in the at-risk group. They had spoken with them and confirmed that they had a PPP in place and recorded the outcome on the PMR. 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 to people which may require further intervention from the pharmacist.

A large proportion of the pharmacy’s workload involved supplying some people’s medicines in multi-compartment compliance packs. This was to help 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 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 packs were annotated with detailed descriptions which allowed people to distinguish between the medicines within them. Team members also recorded the batch number and expiry dates on the medicines within the packs in case of a product recall so that the medicine could be more easily identified. The pharmacy supplied people with patient information leaflets, so they had access to up-to-date information about their medicines. The compliance packs were signed by the dispenser and RP or ACT so there was an audit trail of who had been involved in the

dispensing process.

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, 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 and to manage requests for non-repeat medicines. 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. And they retained a copy of the consultation record form.

The pharmacy had an automated 24-hour collection point. The collection point allowed people to collect their medicines at any time of day, including outside of the pharmacy's opening hours. People were sent a text message indicating their medicines were ready to collect with a pin code. The pin code was used by people to enter on the touch screen system and the prescription could be collected in the collection drawer. It expired after a few days, and this was highlighted to team members to allow the prescription to be removed from the collection point. And this allowed team members to monitor compliance with collection of people's medicines.

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 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 which were operating within the correct temperature range. 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. The pharmacy used an automated measuring machine for dispensing of some CD liquids that was calibrated before use and regularly cleaned. And it documented when these tasks were completed on an electronic log. It also had an automated 24-hour collection point that was serviced regularly by the external provider. And it had access to engineer support via telephone.

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.