General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Marchmont Pharmacy, 41-43 Warrender Park Road, Edinburgh, Midlothian, EH9 1EU

Pharmacy reference: 9012199

Type of pharmacy: Community

Date of inspection: 06/03/2024

Pharmacy context

This is a recently relocated pharmacy in a predominantly residential area near the city centre of Edinburgh. Its main services include dispensing of NHS prescriptions, including serial prescriptions as part of the Medicines: Care and Review service. And it dispenses medicines into multi-compartment compliance packs and pouches to help people take them at the right time. The pharmacy delivers medicines for some people to their homes and to people living in local care homes.

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 suitably manages risks to help team members provide safe services. And it mostly keeps the records it needs to by law. Team members keep people's private information safe. And they know what to do to help protect the health of vulnerable people. Team members discuss the mistakes they make when dispensing. But they do not keep records of these mistakes to help with ongoing learning and improvement.

Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) to help team members manage risks. These had been reviewed by the superintendent pharmacist (SI) in June 2023. A record of competence was attached to each SOP but team members had not signed these to confirm that they read and understood the SOPs. But team members advised they had read the SOPs within the last six months. Team members were aware of their roles and responsibilities and 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 advised they recorded mistakes identified during the dispensing process, known as near misses, on a paper record. But there were no records available to view. The pharmacist explained that following a review of the log, they shredded this in confidential waste. This meant there were no records for the team to refer to. Team members explained errors were highlighted to them by the pharmacist, and they 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. The pharmacy had recently moved premises. Team members described that when moving medicines stock to the new premises, they had considered the safe storage of medicines. And they had ensured that similar products at higher risk of selection error were not located beside each other on the storage shelves. This has included trazodone and tramadol which were placed on separate shelves to reduce the likelihood of a selection error occurring. 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 and then reviewed by the 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 pharmacist manager or SI.

The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, but it could not be seen clearly from the retail area. This was rectified during the inspection. The RP record was compliant. The pharmacy had a paper-based controlled drug (CD) register and the entries checked were in order. Team members occasionally checked the physical stock levels of CDs against the balances recorded in the CD register on dispensing, and they did not complete regular additional audits. A balance check was completed in January 2024 and prior to that in September 2023. This meant there was a risk that some registers may not be checked for some time if the CD was not dispensed regularly, and a discrepancy might not be identified. There was a paper-based patient-returned CD register. Some CDs had been returned the previous day and these were still to be entered into the register. But they were clearly marked and segregated in the CD cabinet. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were

included to provide an audit trail. Private prescription records were not wholly up to date. There was a basket with private prescriptions dating back four weeks previously which had not been entered into the register.

Team members were aware of the need to keep people's confidential information safe. They were observed separating confidential waste into dedicated containers which was then shredded. The pharmacy stored confidential information in staff-only areas of the pharmacy. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. They knew to discuss any concerns with the pharmacist and had access to contact details for relevant local agencies. Recently, the delivery driver had identified a person who had a supply of medicines in multi-compartment compliance packs in their home that they had not taken. The driver informed the pharmacy team who spoke with the person's GP to express their concern. The GP advised to withhold medicines until they had an appointment with the person. 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 right qualifications and knowledge to manage its workload and provide its services. The pharmacy team supports its members to complete appropriate training for their roles and keep their skills up to date. Members of the team work well together and communicate effectively. And they are comfortable raising concerns should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager and they were an independent prescriber (IP). Other team members who worked in the pharmacy included a full-time dispenser, two part-time dispensers, two part-time medicines counter assistants and two delivery drivers. And there was a vacancy for a dispenser. A regular locum pharmacist supported two days per week. Two dispensers managed operations relating to dispensing multi-compartment compliance packs and compliance pouches. And they covered each other's staffing hours during periods of annual leave to provide contingency. A locum pharmacist was also trained to complete these tasks. 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. Part-time staff members were used to help cover absences.

Team members had all completed accredited qualification training or were enrolled on an appropriate qualification training course. Team members who were enrolled on an accredited qualification training course received protected learning time. And all team members had access to additional learning materials relevant to their roles which was provided by the pharmacist. They received some learning time during quieter periods. And recently had completed some training relating to the NHS Pharmacy First Service. A new driver had recently started working for the pharmacy and they had shadowed the other driver as part of their induction training.

The team received regular informal feedback as they worked from the pharmacist and regular locum pharmacist. They also felt comfortable to raise any concerns with their pharmacist manager or SI. The team had some informal meetings to discuss workload plans and updates from the SI. And part-time staff members completed regular hand-over of work discussions to ensure completion of pharmacy tasks. The team also felt comfortable to raise any concerns and suggest improvements to their pharmacist or SI. Recently the pharmacist had suggested a change to the ordering process for repeat prescriptions for the care homes. Pharmacy team members now electronically scanned and securely emailed prescriptions to the care home to enable them to carry out an auditable check of prescriptions. This enabled the pharmacy team to process the home in a more time efficient manner. The team and care home felt this change had improved the quality of the service provided. The SI visited the pharmacy regularly and was available via telephone if the team required urgent support.

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 maintains them to a high standard. It has a private consultation room 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. The dispensary was comprised of two main areas. The dispensary area to the front of the pharmacy was used to label and dispense prescriptions, including serial prescriptions. A bench used by the RP to complete the final checking process was at the front of this area, near the retail counter. The medicines counter could be clearly seen from the dispensary which enabled the pharmacist to intervene in a sale when necessary. The dispensary area to the rear of the pharmacy had an automated dispensing machine to dispense medicines into compliance pouches and team members also assembled multi-compartment compliance packs in this area. This area enabled team members to work without distractions. There was a separate room to the side of the main dispensaries that was mainly used to check prescriptions for the care home. And there was a basement area with additional storage, staff facilities and toilets. A good-sized consultation room could be accessed from the main dispensary and retail area. It was suitably equipped and fit for purpose. This space allowed team members to have private conversations with people. The consultation room was locked to prevent unauthorised access 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 the room temperature to an acceptable level. And there was bright lighting throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. Overall, it manages its services well and they are easy for people to access. The pharmacy receives its medicines from reputable sources and stores them appropriately. And team members carry out checks to help ensure they keep medicines 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 in the window. The team also kept a range of healthcare information leaflets for people to read or take away, these included information on dementia and carer support.

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. Team members signed dispensing labels to maintain an audit trail of who had dispensed and checked the medicines. The team did not provide owing's slips to people when it could not supply the full quantity prescribed. But they advised people of this at the point of prescription collection. And they contacted the prescriber when a manufacturer was unable to supply a medicine to arrange an alternative medicine. The pharmacy offered a delivery service and kept a paper record of deliveries so the team could answer queries from people expecting deliveries. But it did not keep a copy of these records after the delivery day, so the team did not have a copy to refer if people had a query after the delivery date.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And they knew of the additional information to be supplied to help them take their medicines safely. The team were aware of the most recent patient safety alert relating to valproate. The team had recently completed an audit of people who took valproate and did not have anyone in the at-risk group.

The pharmacy provided multi-compartment compliance packs to people to help them take their medication correctly. 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 matched these against the medication record sheet. They documented any changes to people's medication on the record sheets. The packs were annotated with detailed descriptions of medicines in the pack, which allowed people to identify their medicines. The pharmacy supplied people with some patient information leaflets, for example if they had a new medicine in their compliance packs. But they did not regularly provide patient information leaflets for all medicines in the compliance packs. So people may not have up-to-date information about all of 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.

The pharmacy used an automated dispensing machine to dispense medicines into compliance pouches for people living in local care homes. Each individual pouch contained all the person's medicines to be taken at a particular time. The pouch displayed printed information about its contents, including the

name and quantity of each medicine, the day and time the medicines should be taken and the person's details. They were also annotated with detailed descriptions of the medicines which allowed people to distinguish between the medicines within them. Team members inputted the information from the prescription into the patient medication record (PMR) and this was transferred to the automated dispensing machine for assembly. The pouches were transferred into a box with additional labels which were signed by the dispenser and RP so there was an audit trail of who had been involved in the process. Medication administration record charts were also provided. The pharmacist visited the care home on a quarterly basis to complete an audit of the service provided.

The team used barcodes to manage stock in the automated dispensing machine. The medicine was removed from its original packaging and placed into canisters and each canister contained the same batch number and expiry date so that there were no mixed batches. Team members scanned the barcodes from the canister and the medication boxes as an accuracy check. The automated dispensing machine also had loading drawers for some medicines which were not routinely stored in canisters within the machine. For example, some controlled drug medicines. A pharmacist, or experienced member of the team performed a second check before these medicines were loaded into the automated dispensing machine.

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 phoned the pharmacy to advise they required their medicines. This allowed the team to dispense medicines in advance of people collecting. They kept a record of the collection due date and date the prescription was collected. Team members could then identify any potential issues with people not taking their medication as they should. 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 they kept a printed copy. And they kept a printed copy of the consultation forms. The IP pharmacist also prescribed a small number of private prescriptions mostly for people who had travelled to the area and were unable to access NHS services. The pharmacist conducted a consultation with the person, and they obtained evidence of their prescribed medication. And they recorded the consultation on the PMR.

Pharmacy-only (P) medicines were stored behind the pharmacy counter to prevent unauthorised access. The pharmacy obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of between two and eight degrees Celsius. The pharmacist advised that team members checked the expiry dates of medicines every six months and were up to date with the process. And team members checked expiry dates of medicines during the dispensing process. Medicines due to expire soon were highlighted. A random selection of medicines were checked and all were found to be within their expiry date. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove and quarantine affected stock. They returned items received damaged or faulty to manufacturers as soon as possible. The pharmacy had medical waste bins for pharmaceutical waste. There was a large amount of pharmaceutical waste stored in boxes in a staff-only area of the pharmacy, but this had not been transferred into the appropriate waste bins. The pharmacist advised they would rectify this.

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 counters. The automated dispensing machine for compliance pouches had recently been serviced and had planned regular servicing by the external provider. And engineer support was available via telephone and an instant messaging platform 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.