

# Registered pharmacy inspection report

**Pharmacy Name:** Holm Pharm, 84A West Johnstone Street, ALVA,  
Clackmannanshire, FK12 5BD

**Pharmacy reference:** 1041946

**Type of pharmacy:** Community

**Date of inspection:** 13/11/2023

## Pharmacy context

This is a community pharmacy in Alva. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has procedures to help make sure the team provides services effectively. Team members are able to access the procedures on their personal phones and not on the pharmacy's operating system. This means there are barriers for locum pharmacists and other team members that are new to the pharmacy. The pharmacy team members discuss mistakes that happen when dispensing. They keep records to identify patterns in the mistakes they make. And then take the opportunity to improve and reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And team members mostly keep confidential information safe. They understand their roles in protecting vulnerable people and discuss concerns with the pharmacist.

### Inspector's evidence

Team members were able to access the company's digital standard operating procedures (SOPs) on their personal phones. But there was no access to them on the pharmacy systems. This meant that locum pharmacists and others did not have access to the procedures and the responsible pharmacist (RP) could not verify that team members had been trained to follow them. A sample of the procedures on one of the dispenser's phone showed they were valid until at least April 2024. The procedure for carrying out the final accuracy check was valid until October 2025. The accuracy checking dispenser (ACD) confirmed they followed the procedure and knew only to check prescriptions that had been clinically checked and verified by a pharmacist. Team members signed medicine labels to show who had dispensed and who had checked prescriptions. This meant the responsible pharmacist (RP) and the ACD were able to help individuals identify and learn from their dispensing mistakes. Team members had been recording their near miss errors on paper records. The RP was currently transferring the records, so they were kept digitally and once completed they intended to train the team members to use the new system. The RP carried out near miss error reviews, but they had not identified any patterns and trends. Most of the errors were due to team members rushing and not taking sufficient time to carry out the necessary checks. Team members were aware of look alike and sound alike (LASA) medicines. And they had separated a few of them to manage the risk of selection errors. For example, separating procyclidine and prochlorperazine and the different strengths of pregabalin. They also had used shelf-edge caution labels to highlight different pack sizes for some medicines.

Team members knew how to manage complaints. And a notice at the medicines counter provided information about how to provide feedback. Team members knew to report dispensing mistakes that people reported after they left the pharmacy. The pharmacy kept records of dispensing incidents, but these were not comprehensive and did not provide details of the investigation or any improvements that they made. The RP provided learnings from a recent incident which included a team discussion about labelling instructions when the directions were complex. This included checking with the pharmacist beforehand.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 1 August 2024. The pharmacist displayed an RP notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. But not all RPs had documented the time they

finished at the end of the day. Team members completed a tracker to ensure they carried out essential tasks to meet the company's governance arrangements. This included documenting the checking and verification of controlled drug (CD) balances once a month. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. They filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of specials that were up to date. Team members understood data protection requirements and how to protect people's privacy. And they disposed of confidential waste in a designated container that was removed and destroyed at an offsite location. A notice at the medicines counter provided information about the pharmacy's compliance with data protection legislation. Team members understood their obligations to raise safeguarding concerns. For example, the delivery driver knew to escalate concerns to the RP.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

Pharmacy team members mostly have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. They have access to learning to further develop their skills and knowledge and keep up to date.

### Inspector's evidence

The pharmacy's prescription workload had increased slightly over the past year and there continued to be sufficient staffing levels to manage it. Contingency arrangements were in place with no more than one team member permitted to take leave at the one time. The pharmacy was busier at the start of the week and a rota was in place to meet extra demands. This also ensured that team members rotated and maintained the necessary competencies to carry out all the relevant pharmacy tasks. The regular pharmacist manager was on leave, and two regular locum pharmacists had been arranged to provide cover. Team members were mostly long-serving and experienced in their roles and responsibilities. This included the following staff. One full-time pharmacy technician, one part-time accuracy checking dispenser, four part-time dispensers and two delivery drivers. Team members were unable to confirm whether the delivery drivers had completed the necessary qualification training they needed to carry out their roles.

Team members supported new colleagues when they took up their posts. They had supported a new dispenser to operate the patient medication record (PMR) as it was different to the system they had used in a previous post. The pharmacy supported team members to learn and develop. One of the dispensers had been encouraged to enrol on qualification training and on completion had recently registered as a pharmacy technician. A new Saturday team member was about to be enrolled on training and the pharmacy provided protected learning time in the workplace. The company provided access to a range of eLearning modules, but team members had been having difficulties accessing and navigating the website. The superintendent pharmacist (SI) provided a list of training modules that they expected team members to complete every month throughout the year. Modules had included diet and physical exercise, but a checklist showed that team members had only completed training up until June 2023. The RP ensured the pharmacy team was up to date with new medicines, and they had discussed Flixkoh Airmaster that was being used alongside other treatments for asthma. The pharmacy encouraged team members to make suggestions for improvements. Team members were aware of their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises support the safe delivery of its services. But team members do not always adequately use the facilities to safeguard medicines and confidential information. The pharmacy effectively manages the space for the storage of its medicines. It has suitable arrangements for people to have private conversations with the team.

### Inspector's evidence

The premises provided a modern, purpose-built environment from which to safely provide services. A sound-proofed consultation room was available for use. And it provided a confidential environment for the provision of services. People could speak freely with the pharmacist and the other team members during private consultations. Team members regularly cleaned and sanitised the pharmacy. This ensured it remained hygienic for the services it provided. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate area provided adequate space for team members to take comfort breaks.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

### Inspector's evidence

A step-free entrance provided access to the pharmacy, and this helped people with mobility difficulties. The pharmacy opened from 09.00 to 12.00 on a Saturday. And a nearby sister branch opened between 13.00 to 16.00 to increase local access to pharmacy services in the area. The same team members worked across both sites to optimise staffing arrangements. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. This included the checking of dates to identify and remove items before they expired. Team members documented the checks on a matrix, and this helped them to identify when checks were next due. They also attached stickers on short-dated packs so that team members were alerted. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. Team members kept an audit trail to show the fridge had remained within the accepted range of between two and eight degrees Celsius. Fridge stock was organised, and team members used plastic bags to segregate those items that had been dispensed. This also helped team members carry out extra checks at the time they made supplies.

Team members kept stock neat and tidy on a series of shelves. And they used two secure CD cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept well-segregated from other stock. For example, a designated cabinet was used for multi-compartment compliance packs. Team members received notifications of drug alerts and recalls which they prioritised, and they evidenced they checked for affected stock. This provided the necessary assurances that they removed and quarantined affected stock straight away. For example, they had checked for Trimbaw inhalers in September 2023. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The RP had discussed the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. Team members knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. They also knew to make supplies in the original container and not to split packs to comply with recent legislative changes.

The pharmacy supplied multi-compartment compliance packs to help people with their medicines. Team members had capped the numbers they dispensed due to space and available resources. A separate rear area was used to safely assemble and store the packs. And team members took it in turns to carry out dispensing and associated tasks. They used trackers to schedule dispensing and referred to supplementary records that provided a list of each person's current medication and dose times. They checked new prescriptions against the records for accuracy and contacted prescribers

to confirm any changes. Forms were used to document prescription changes that the surgery notified them about and these were filed alongside people's records.

The pharmacy used dispensing baskets to highlight the different types of prescriptions it received. This also helped team members keep medicines and prescriptions together during the dispensing process and to manage the risk of items becoming mixed-up. The pharmacy provided descriptions of medicines and supplied patient information leaflets (PILs) for people to refer to. Some people collected the packs either by themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns.

In 2022, the pharmacy had started dispensing serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The level of dispensing had not increased and had remained around the same over the past year. The pharmacy had a system for managing dispensing and they recorded supplies on trackers, so they knew when subsequent supplies were due. They retrieved prescriptions once a week so they could order and dispense them for the following week. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could intervene and discuss compliance.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets. They cleaned the pharmacy on a regular basis to ensure adequate levels of hygiene were maintained.

### 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.