General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Holm Pharm, Mains Street East, MENSTRIE, Clackmannanshire, FK11 7BJ

Pharmacy reference: 1041950

Type of pharmacy: Community

Date of inspection: 17/05/2019

Pharmacy context

The pharmacy is on the main road in the centre of Menstrie, and it lies 5 miles east-north-east of Stirling. The pharmacy provides an NHS prescription collection service. And it offers a range of extra services. The pharmacy supplies medicines in multi-compartmental compliance packs to help people take their medicines. And it provides a prescription delivery service when needed. A consultation room is available, and people can be seen in private.

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 team members complete training and work to professional standards. They provide safe services and look after people. The pharmacy keeps records of mistakes when they happen. And senior pharmacy team members carry out checks to make sure the pharmacy is running safely. The pharmacy team discusses the need for new safety measures. And agrees when service improvement is needed. The pharmacy keeps the records it needs to by law. It understands its role in protecting vulnerable people. And it trains the pharmacy team to keep confidential information safe. People using the pharmacy can raise concerns. And staff know to follow the company's complaints handling procedure. This means that staff listen to people and put things right when they can.

Inspector's evidence

The pharmacy displayed the responsible pharmacist notice. And people could identify who was in charge.

The pharmacy team signed to confirm they followed standard operating procedures (SOPs). And the SOPs defined the pharmacy processes and staff responsibilities. The pharmacy had developed and implemented the latest SOPs in 23 January 2018. And a review date of January 2019 had been agreed. The short review date was due to a new falsified medicines directive (FMD) being introduced in February 2019. And the potential for procedural changes.

The pharmacy team mostly signed dispensing labels to show they had completed a dispensing task. But, they did not always sign multi-compartmental compliance packs. The pharmacy had recently introduced a quadrant stamp to record initials on prescriptions.

A pharmacist had been recruited into a new area business development role in January 2019. And a pharmacy technician had been recruited into a patient safety role at the beginning of April 2019. This had resulted in many service improvements including improved near-miss recording and reviews.

The pharmacist checked prescriptions and gave feedback to dispensers when they failed to identify their own errors. The pharmacy technician had been coaching the pharmacy team to improve the quality of their near-miss entries and their accuracy in dispensing. This ensured that more near-misses were identified and corrected before passing for a final accuracy check.

The pharmacy had introduced a monthly near-miss review. And the findings were discussed amongst the pharmacy team. This ensured they identified patterns and trends and they took improvement action to avoid the same thing happening in the future. A near-miss report for the previous month showed that formulations were being mixed up. The pharmacy team had agreed to circle the formulation on the prescription to confirm they had carried out a thorough check.

The company had arranged for a manager’s meeting to take place every three months. And they planned to discuss the near-miss reports from all the branches and cascade learnings to all branches.

The pharmacy team were proactive at highlighting look-alike and sound-alike medicines. For example, they had separated ibuprofen five per cent and ten per cent gel following a selection error. The pharmacy team had introduced clear plastic bags for insulin products so that additional checks could be easily completed.

The pharmacist managed the incident reporting process. And the pharmacy team had been trained to fill-in the company's incident report form. The pharmacy team knew when incidents had happened and what the cause had been. For example, they knew about a mix-up with baclofen and Buscopan. And the products had been separated and a shelf-edge caution label applied.

A complaints policy ensured that staff handled complaints in a consistent manner. And a pharmacy notice in the waiting area informed people about the complaints process and provided contact details. The company had issued questionnaires to gather feedback about the services they provided. This had generated mostly positive feedback with no suggestions for improvement.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a regular basis. The pharmacy recorded controlled drugs that people returned for destruction. The staff destroyed the controlled drugs on a regular basis. And recorded their names once completed. A sample of private prescriptions were up to date and met legal requirements. A sample of specials records were up to date. And the pharmacy team recorded the name of the person who had received the medication.

The pharmacists used patient group directions to improve access to medicines and advice. A sample trimethoprim patient group direction was valid until October 2020.

The pharmacy team completed data protection training on a regular basis. And recent training had included the general data protection regulations. The pharmacy team had completed an assessment so that the pharmacist could check that knowledge was updated. The pharmacy displayed a notice that showed it was registered with the information commissioner's office. And displayed a privacy notice to ensure that people understood that personal information was safeguarded.

The staff disposed of confidential information using an onsite shredder. And a collection service uplifted the bags for off-site shredding. The pharmacy team archived spent records for the standard retention period. And they stored prescriptions for collection out of view of the waiting area. The pharmacy team took calls in private using a portable phone when necessary. And used individual passwords to restrict access to patient medication records.

The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the pharmacy had registered the pharmacist and the pharmacy technician. The pharmacy team had completed a centre for pharmacy postgraduate education (CPPE) training module in 2017. And knew how to raise concerns when they recognised the signs and symptoms of abuse and neglect. Staff were aware of vulnerable groups. And key contact details were available should a referral be necessary. The pharmacy team provided examples of referrals such as having to phone the GP when they identified someone who was not coping well with day to day life.

Public liability and professional indemnity insurance were in place. And expired on 31 August 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at regular review meetings. This ensures they keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. They can speak up and suggest service improvements. They share ideas and learnings to keep services are safe.

Inspector's evidence

The pharmacy work-load had remained stable over the past year.
The pharmacist had worked at the pharmacy for around 18 months. And confirmed that the staffing level was adequate. The company had recently appointed a new pharmacy technician. The new pharmacy team member was updating the knowledge and skills needed to carry out final accuracy checks. And once re-accredited would be carrying out checks in each of the four branches one day each week to support the pharmacists.

The pharmacy kept staff qualifications on-site so that evidence of accreditation was available. The pharmacy team members were mostly long-serving and experienced. And the following staff were in post: one full-time responsible pharmacist; one x one day pharmacy technician; two x two days trainee pharmacy technician; one x four days accuracy checking dispenser; two x two and a half days dispenser; three x 28 hours dispenser; one x 35 hours dispenser; one x 38 hours dispenser/supervisor and one x 21 hours dispenser.

The pharmacy allowed one member of staff to take annual leave at the one time. And part-time staff increased their hours to ensure there was enough cover to complete tasks.

The pharmacy team knew what company targets were in place. And were registering people with the chronic medication service. The pharmacy team were not under pressure. And only registered people that were suitable for services.

The pharmacy had introduced an annual appraisal. And provided a range of training activities so that the pharmacy team could develop and improve their performance. The pharmacy team provided many examples of training. And produced training records to show what they had completed. For example, the pharmacy team had recently completed training to ensure they asked open questions when asked for over-the-counter painkillers. And they had identified people who were at risk of addiction and who needed advice to take their medication according to instructions. The pharmacy provided training so that the pharmacy team could comply with the company's governance arrangements. And this included information governance and safeguarding training.

The pharmacy team members were supported to raise concerns and provided suggestions for improvement. For example, they identified the need for individual nhs.net e-mail addresses. And this ensured they were able to support locum pharmacists. Such as, checking for drug alerts and removing stock with the time-scale specified.

The pharmacist discussed queries with patients. And gave advice when handing out prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for patients to receive healthcare.

Inspector's evidence

The pharmacy maintained and cleaned the premises on a regular basis and kept the waiting area in good condition. This presented a professional image to the public. The pharmacy provided seating in the waiting area. But, only a few patient information leaflets were available for self-selection.

The pharmacy had allocated benches for the different dispensing tasks. And the pharmacy team dispensed walk-in prescriptions near to the waiting area. The pharmacist supervised the medicines counter from the checking bench. And made interventions when needed.

A security alarm and shutters protected the pharmacy after hours. And panic buttons and CCTV were available. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

A consultation room was available and professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to the local population. It dispenses multi-compartmental compliance packs for people who need extra help with their medicines. And provided an NHS prescription collection and delivery service when needed. The pharmacy provides service information in the window. But, it only provides a limited range of information leaflets for self-selection. This could be improved upon to ensure that people are up to date. The pharmacy manages its services. And updates the pharmacy team about high-risk medicines. This means that staff are up to date with current safety messages. The pharmacy sources, stores and manages medicines to ensure they are fit for purpose. And it has the capability to follow the new falsified medicines directive.

Inspector's evidence

The pharmacy had steps into the premises. But also provided a ramp for people with mobility difficulties. The pharmacy had installed a door-bell at the entrance. And this alerted the pharmacy team who helped people when necessary. The pharmacy displayed its opening hours at the front of the pharmacy. But, only provided a limited range of information leaflets for self-selection. For example, they did not provide information about the electronic minor ailments scheme or the chronic medication service.

The pharmacy had been identifying people suitable for the chronic medication scheme for about a month. The pharmacy team attached a questionnaire to prescription bags for people to fill out. And the pharmacist reviewed the forms to identify people who needed help taking their medication. The pharmacy was yet to receive serial prescriptions.

The pharmacist intervened to make sure that people got the most out of their medicines. For example, contacting a GP due to frequent prescriptions for oxycodone liquid. This had resulted in prescription changes and supplies being made on a weekly basis.

The pharmacy provided an NHS prescription collection service. And dispensed prescriptions mainly from the Alva health centre. The pharmacy provided an NHS prescription delivery service to housebound and vulnerable people. And made sure that people signed for prescriptions to confirm receipt.

The dispensing space was adequate. And the pharmacy team had allocated benches for the various dispensing tasks. The pharmacy technician and the pharmacist had agreed to share the checking bench. And they had identified a series of shelves above the bench for prescriptions awaiting a final accuracy check. The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process.

The pharmacy provided multi-compartmental compliance packs to people who needed extra support to take their medicines. And used an NHS Forth Valley questionnaire to make sure people were able to use the packs before they were supplied.

The pharmacy team used trackers to manage the work-load, and this ensured that people did not go without their medication. The pharmacy team recorded prescription changes on the patient's records. And the pharmacist checked to confirm that the electronic patient medication record had been updated.

The pharmacy team kept the packs on a quarantine shelf when people were in hospital. And this ensured they were not issued by mistake. The pharmacy team supplied patient information leaflets and descriptions of medicines. And this supported people and their carers to help them take their medicines as intended.

The pharmacy team kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers.

The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs. They monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees.

The pharmacy team accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked stocks of co-amoxiclav in May 2019 with none found.

The pharmacist had carried out checks to identify people who were taking Valproate medication. And had contacted the GP to discuss someone who was being prescribed Epilim liquid. The pharmacist had briefed the pharmacy team about the use of Valproate in women. And they demonstrated an understanding of the pregnancy protection scheme and where to find safety leaflets and cards.

The pharmacy had installed a bar-code reader and the associated software needed to follow the falsified medicines directive (FMD). The pharmacy team understood the system and checked for labels that met FMD requirements. And when identified the labels were scanned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services.

Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And it had a separate range of measures for measuring methadone. The measures were marked red for methadone and others were available for measuring other liquids such as antibiotics.

The pharmacy had a range of equipment for counting loose tablets and capsules. And a separate triangle was used for cytotoxic medication.

Cleaning materials were available for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes.

A consultation room was available. And the pharmacy protected people's privacy and dignity.

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.