

Registered pharmacy inspection report

Pharmacy Name: Holm Pharm, 50-52 Johnston Avenue, Stirling,
Stirlingshire, FK9 5DJ

Pharmacy reference: 9011346

Type of pharmacy: Community

Date of inspection: 05/10/2023

Pharmacy context

This is a community pharmacy in Stirling. 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
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

Pharmacy team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members follow safe working practices. And they can show some learning from their mistakes. But they do not always take the opportunity to do so. This creates a barrier to managing risks and introducing safety improvements.

Inspector's evidence

Team members were unable to access the company's digital standard operating procedures (SOPs). This was due to recent changes and the company moving to a web-based system. The superintendent pharmacist (SI) had been in touch with the system provider, and they were in the process of resolving the issue. Team members had access to hard copy SOPs, but these had expired in October 2021. Team members signed medicine labels to show who had dispensed and who had checked prescriptions. This meant the responsible pharmacist (RP) was able to help individuals identify and learn from their dispensing mistakes. Team members had not been recording their near miss errors due to difficulties accessing the digital records they were required to use. This meant the pharmacy was less likely to identify patterns and trends and less likely to introduce new safety measures to manage new and emerging dispensing risks. 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, different strengths of propranolol and separating promethazine and prazosin.

Team members had good access to the SI who visited the pharmacy on a regular basis to confirm it was running safely and effectively. 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. And the RP was required to complete a report using an electronic template which they sent to the SI's office. The template included a section to record information about the root cause analysis and any mitigations they introduced to improve safety arrangements.

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 3 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. Team members maintained the controlled drug (CD) registers and kept them up to date. And they evidenced that they conducted a balance check once a week. 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. Team members 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 the company's head office. 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. And team members including the delivery driver knew to escalate concerns to the RP. For example, when people were not at home as expected. This meant that team members could

contact the relevant agencies to share their concerns. The pharmacy had contact details for ease of access.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members 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 eLearning to further develop their skills and knowledge, but they do not always do so.

Inspector's evidence

The pharmacy's prescription workload had increased since the closure of a nearby pharmacy and the SI had arranged extra cover to help manage the increased workload. They were also monitoring the workload and the pharmacy's staffing arrangements to ensure there was sufficient cover. The regular RP had recently left their post and one of the company's relief RPs had been providing cover. This was due to continue until the regular RP's replacement took up their post in December 2023. Team members were long-serving and experienced in their roles and responsibilities and the following staff worked in the pharmacy. One full-time dispenser, three part-time dispensers and two part-time delivery drivers. A new team member who started in March 2023 had recently achieved a dispenser qualification. They had been supported and the RP had allocated protected learning time in the workplace. The company provided access to a range of eLearning modules, but completion of modules was not mandatory and completion of courses was not monitored. Team members had not accessed learning in the past year since the pharmacy's workload had started to increase.

Team members has not been recording near miss errors so they could identify and learn about new and emerging risks in the pharmacy. There was some evidence that team members had been proactive at managing dispensing risks. And they had discussed a particular manufacturer and the changes they had made to their packaging which had created selection risks. This included similar pack sizes for different quantities such as 28 and 100 tablets which had caused confusion. 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. And it effectively manages the space for the storage of its medicines. The pharmacy 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. Three sound-proofed consultation rooms were available for use. And they provided a confidential environment for the provision of services. People could speak freely with the pharmacist and the other team members during private consultations. The rooms were organised for specific services, and people that regularly attended the pharmacy knew which room to use. Team members regularly cleaned and sanitised the consultation room and the pharmacy. This ensured they 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 room 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 purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. But they could not always provide audit trails to show they did so. For example, red dots had been attached to short-dated items, but there was no evidence to confirm when date checks had last been completed. The pharmacy used a large fridge to keep medicines at the manufacturers' recommended temperature. And team members checked and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. Team members placed items in clear plastic bags. This helped them to conduct extra checks when they made supplies. Team members kept stock neat and tidy on a series of shelves. And they used secure CD cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept well-segregated from other stock. A separate cabinet was used for multi-compartment compliance packs.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. 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. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They 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. The pharmacy supplied original packs which contained patient information leaflets and information cards.

The pharmacy was supplying an increasing number of multi-compartment compliance packs to help people with their medicines. Team members used a separate rear area to safely assemble and store the packs. And a nominated team member was responsible for managing the dispensing of packs to ensure they were available for collection or delivery as previously agreed. Another trained team member provided cover when the lead dispenser was on leave. Team members referred to trackers which helped them plan dispensing. And they referred to supplementary records that provided a list of each person's current medication and dose times which they kept up to date. They checked new prescriptions against the records for accuracy and contacted prescribers to confirm any changes. Team members used a large notice board to communicate changes. For example, when people had been admitted to hospital and their packs had been isolated on a separate designated shelf. The pharmacy used dispensing baskets to highlight the different types of prescriptions it received. And it used larger baskets for pack dispensing. This helped to keep medicines and prescriptions together during the dispensing process and to manage the risk of items becoming mixed-up. Team members provided descriptions of medicines. And they supplied patient information leaflets 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.

The pharmacy dispensed serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The pharmacy had a system for managing dispensing and they recorded supplies, so they knew when subsequent supplies were due. They retrieved prescriptions once a week on a Monday 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. They also used an automated dispensing machine for methadone, which they calibrated and cleaned each day. 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. Team members cleaned and sanitised the pharmacy on a regular basis.

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.