

# Registered pharmacy inspection report

**Pharmacy Name:** Holmscroft HC Ltd, Greenock Health and Care Centre, Wellington Street, Greenock, Inverclyde, PA15 4NH

**Pharmacy reference:** 9011604

**Type of pharmacy:** Community

**Date of inspection:** 14/12/2021

## Pharmacy context

This is a community pharmacy in a health centre in Greenock. 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). The inspection was completed during the COVID-19 pandemic.

## 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

Pharmacy team members mostly follow good working practices. And they show that they are managing dispensing risks to keep services safe. The pharmacy documents its near miss errors and it learns from its mistakes. It keeps the records it needs to by law, and it suitably protects people's private information.

### Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus and notices reminded people of the signs and symptoms. Team members asked people to wear face coverings and directed them to supplies provided by the health centre next door if they arrived without one. The waiting area was large with seating for 20 people. Team members had limited the number of people waiting to ten at a time to help them keep a safe distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and throughout the dispensary. A plastic screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were wearing face masks throughout the inspection. The pharmacy used working instructions to define the pharmacy's processes and procedures. The superintendent pharmacist worked onsite and had authorised the procedures for use in October 2019. They reflected most of the working practices and team members had recorded their signatures to show they had read and understood them. An operating manual was currently being used for a new dispensing robot that had been installed at the time the pharmacy had relocated in May 2021. The superintendent pharmacist was in the process of developing new procedures for the robot with a completion date of early 2022. The pharmacy employed an 'accuracy checking technician' (ACT) and the final accuracy checking process had been defined and documented. The pharmacists and the ACT did not always follow the procedure. The pharmacists did not annotate prescriptions to indicate a clinical check had been carried out. The ACT mostly checked multi-compartmental compliance packs. Dispensing of packs was carried out by experienced dispensers. They followed safe dispensing practices which involved checking prescriptions against the pharmacy's supplementary records. This reduced the risk of dispensing errors when carrying out the final accuracy check. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. The pharmacists and the ACT spoke to team members to help them learn from their dispensing mistakes. And they recorded near miss errors to identify patterns and trends which they acted on. The records showed the number of near-miss errors had fallen following the installation of a dispensing robot and team members were aware of the dispensing risks associated with the robot. This included generating labels with bar codes for 'parallel import packs' (PI packs) that did not always have a bar-code label to scan them into the robot. They knew to take care following a few labelling errors. This included applying a Serevent label to a Seretide inhaler. Team members managed selection errors for those items not kept in the robot, such as separating Novorapid Flexpen and Novorapid Flextouch. The pharmacists kept electronic reports following dispensing incidents. This included information about the root cause and any improvements they had made to manage the risk of it happening again. The

pharmacy trained its team members to handle complaints and had defined the complaints process in a documented procedure for team members to refer to. It did not display contact details to advise people how to submit a complaint.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurance in place, and they were valid until 30 April 2022. The pharmacist in charge displayed a responsible pharmacist (RP) notice and kept the RP record up to date. Team members maintained the electronic controlled drug registers and kept them up to date. They checked and verified the stock at least once a month and methadone balances once a day. The superintendent pharmacist annotated the electronic Methamphetamine registers once a day to confirm that all entries had been made and the registers were up to date. A destructions register was used to record controlled drugs that people returned for destruction. The register listed items that had been returned for destruction. The superintendent pharmacist confirmed they had witnessed all the destructions, but they had failed to sign and date the entries. Team members kept prescription forms in good order. For example, they kept records of the 'specials' supplies they had made. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Separate bags were used to dispose of confidential waste, and an approved contractor collected them for off-site destruction. The pharmacy did not display a notice to inform people about how it used or processed their information. The pharmacy trained its team members to manage safeguarding concerns, but it had not introduced a policy for them to refer to. They knew to speak to the pharmacist whenever they had cause for concern. The pharmacy supplied multi-compartment compliance packs to a significant number of people. Team members used a series of shelves to store them until they were collected by people or their carers. They checked the shelves on a regular basis to make sure they collected them on time and took action when they failed to collect them. They also contacted the community addictions team if they had concerns when people failed to collect supervised doses. The superintendent pharmacist was in the process of supporting one of the pharmacists to register with the protecting vulnerable group (PVG) scheme. This also helped to protect children and vulnerable adults.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

Most of the pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They complete training as and when required. And they learn from the pharmacist to keep their knowledge and skills up to date.

### Inspector's evidence

The pharmacy's workload had decreased since the start of the coronavirus pandemic. The superintendent pharmacist had maintained the number of team members. This was due to workflow changes which were more resource intensive. It was also due to an anticipated increase in the number of prescriptions following a relocation in May 2021. Most of the team members were long-serving and experienced in their roles and responsibilities. The pharmacy team included one full-time superintendent pharmacist, one full-time pharmacist providing double cover, one full-time ACT, three part-time pharmacy technicians, six part-time dispensers and one pharmacy assistant. The pharmacy assistant managed stock which included putting items into the dispensing robot and checking expiry dates. They followed the pharmacy's working instructions, but they had not completed any formal training to accredit them to do so. Team members had been adjusting to new ways of working following the pharmacy's relocation. For example, the manufacturer of the dispensing robot had delivered onsite training over a period of two days, so they were competent in its operations. The pharmacist kept team members up to date with the relevant coronavirus initiatives and had recently trained team members to provide supplies of lateral flow tests. They had provided around 50 boxes of lateral flow tests the day before the inspection due to the emergence of a new Covid-19 variant. The pharmacist had provided re-fresher training so that team members knew how to process prescriptions for 'specials' and how to correctly endorse supplies for re-imburement. Team members understood the need for whistleblowing and felt empowered to raise concerns when they needed to.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is modern, purpose-built, and professional in appearance. It has a large sound-proofed room and private booth where people can have private conversations with the pharmacy's team members.

### Inspector's evidence

The dispensary was modern and large with ample storage space and dispensing benches. Team members used workstations that were at least two metres apart. This kept them a safe distance from each other throughout the day. The pharmacist was able to supervise the main medicines counter from the checking bench and intervene and provide advice when necessary. A separate area was used to assemble multi-compartment compliance packs and team members kept the storage shelves well-organised. Team members used a robot for dispensing and they vacuumed the floor surface once a week to keep dust-levels down.

Team members had access to a small kitchen area and rest room. Only one team member at a time used the area so they could safely remove their face mask. A sound-proofed consultation room and a separate private booth were in use. They provided a confidential environment to have private consultations. The consultation room was well-equipped with a sink and hot and cold running water. Another sink was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy twice a day to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services which are easily accessible. And it generally 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 carries out checks to make sure medicines are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. A step-free entrance and an automatic door provided unrestricted access for people with mobility difficulties. People could also enter the pharmacy from inside the health centre. The pharmacist had been responding to an increased demand for access to 'prescription only medicines' via 'patient group directions' (PGDs). This included treatments for skin conditions. Team members had organised the dispensing benches and they were clutter-free. They used dispensing baskets to manage the risk of items becoming mixed-up and they kept stock neat and tidy on a series of shelves and inside a dispensing robot. The pharmacy had six controlled drug cabinets and it had ample space to segregate items, for example methadone, multi-compartment compliance packs, general stock and items awaiting destruction were all kept separate. The pharmacy purchased medicines and medical devices from recognised suppliers and team members regularly checked stock to ensure it was in date. The dispensing robot recorded expiry dates when stock was loaded, and team members checked the system once a month for stock that was about to expire. The pharmacist had followed the manufacturer's recommendations and had excluded medications that were unsuitable such as fridge items, controlled drugs, and bulky items. Team members checked the expiry dates of all stock once a month. Three glass-fronted medical fridges were in use. Two were used for stock and the third fridge was used for dispensed prescriptions awaiting collection or delivery. Team members monitored and documented the fridge temperatures which were within the accepted range at the time of the inspection. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members only supplied original packs which contained patient information leaflets and warning cards.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. And it had defined the assembly and dispensing process in a documented 'standard operating procedure' (SOP). A separate area was used to assemble the packs. And a separate storage area was kept well-organised. An experienced dispenser was responsible for ordering the prescriptions to ensure that packs were assembled and supplied in good time. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber and they recorded changes on people's records. Team members supplied patient information leaflets with the first pack of the four-week cycle. They did not annotate descriptions of medicines on the packs. Team members used a Methameasure system for measuring methadone doses. The pharmacist checked new prescriptions at the time they were entered onto the system, and they carried out an accuracy check at the time the doses were dispensed and supplied. Team members accepted unwanted medicines from people for disposal and donned

disposable gloves before processing the waste for destruction. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. They did not keep records of the checks they carried out. The pharmacist confirmed they had received a recent alert for Mydrilate eye drops and on checking found zero stock.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy's equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. A separate measure was used for methadone. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks and gloves. A dispensing robot was in use and a service contract was in place to manage the risk of breakdowns. The engineer was available to resolve issues either remotely or on-site visits. The emergency hotline number was attached to the door. Team members knew how to retrieve stock in the event of a breakdown.

### 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.