

Registered pharmacy inspection report

Pharmacy Name: D & R Sharp (Chemists) Ltd., 59 Montrose Avenue, Intake, DONCASTER, South Yorkshire, DN2 6QP

Pharmacy reference: 1039161

Type of pharmacy: Community

Date of inspection: 18/09/2019

Pharmacy context

This is a community pharmacy in a residential area of Doncaster, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes.

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	1.2	Good practice	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They continually discuss any learning and make changes to their practice to improve patient safety. And they complete regular reviews to measure the effectiveness of these actions.
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 identifies and manages the risks associated with its services. It keeps all records it must by law. And it keeps people's private information secure. The pharmacy advertises how people using its services can provide feedback. And it responds appropriately to the feedback it receives. It has procedures to support its team members in recognising and reporting concerns to protect the wellbeing of vulnerable people. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They continually discuss any learning and make changes to their practice to improve patient safety. And they complete regular reviews to measure the effectiveness of these actions.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). Most SOPs had been first implemented between 2013 and 2015. The responsible pharmacist (RP) on duty was the pharmacy manager. She had worked at the pharmacy for some years and led the SOP review process at least every two years. Pharmacy team members had signed SOPs to confirm they had read and understood them after initially commencing their roles. But they had not re-read the SOPs following the documented review dates. This approach would help refresh their understanding and support continual learning. SOPs included the roles and responsibilities of pharmacy team members. The dispenser demonstrated and explained different aspects of her role clearly throughout the inspection process. And referred queries to the RP when appropriate.

Workflow in the dispensary was efficient. Pharmacy team members completed labelling and assembly tasks in different areas of the dispensary. And the RP had clear space to complete the final accuracy check of medicines. The pharmacy identified high-risk tasks appropriately. For example, the RP managed the supervised consumption service. The pharmacy used a MethaMeasure machine to help manage this service. But the pharmacy did not always use some of the safety tools available through the MethaMeasure software, such as taking and attaching photographs to people's profiles to assist with identification checks. The RP explained people were asked to bring formal identification when they first enrolled on the service. The RP was observed checking people's details against prescription forms and checking the form against information on the MethaMeasure screen when supervising consumption. And cups were appropriately labelled with details of the medication inside.

The pharmacy had some continual risk management processes in place. For example, it maintained an up-to-date locum information pack to support pharmacists who covered the regular pharmacist's leave. The pharmacy completed risk reviews to support pharmacy team members in managing identified risks. For example, the RP had led a review about the use of key codes when making deliveries to people in their own homes. And as a result of the review it had strengthened processes around its delivery service.

Pharmacy team members took ownership of the mistakes they made during the dispensing process by engaging in feedback with the pharmacist at the time they were identified. Following this feedback an entry in the near-miss error reporting record was made. Entries included details of contributing factors and a clear review of each mistake. This review focussed on reducing risk. For example, the similarity of packaging between carbocisteine capsules and gabapentin capsules was discussed and stock locations

checked following a picking error. And there was a focus on separating and highlighting 'look alike and sound alike' (LASA) medicines on the dispensary shelves. The pharmacy had an incident reporting process in place. It reported its dispensing incidents through the National Reporting and Learning System (NRLS). The RP explained how a dispensing incident would be managed. And this included onward reporting to the superintendent pharmacist.

The RP led a patient safety review each month. The review recapped on mistakes and actions taken to manage these throughout the month. It also provided the team with the opportunity to review interventions and other factors affecting patient safety. For example, medicine recalls. The pharmacy maintained comprehensive copies of its reviews. And it shared the learning with its team members. The dispenser discussed recent actions taken following the review process. And pharmacy team members explained how they were working to reduce the risk of distraction during the dispensing process.

The pharmacy had a complaints procedure in place. It advertised how people could provide feedback or raise a concern about the pharmacy. And it recorded details of concerns and submitted these annually to the NHS as part of its contract monitoring processes. Pharmacy team members explained that feedback was mostly positive, and they worked to support people by liaising with surgeries on their behalf. For example, by informing surgery teams when there were medicine availability issues. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'. And it displayed the results of its most recent questionnaire clearly on the consultation room door.

The pharmacy had up-to-date indemnity insurance arrangements in place through the National Pharmacy Association (NPA). The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record were completed in accordance with requirements. Samples of specials records and the prescription only medicine (POM) register complied with legal and regulatory requirements. The sample of the controlled drug (CD) register examined was compliant with legal requirements. But there were some loose sections of the register which required securing. The pharmacy maintained running balances of CDs. The RP routinely checked running balances of each CD as it was received and supplied. And full balance checks of all stock were made at approximately quarterly intervals. A discussion took place about the benefits of increasing the frequency of full balance checks. This would help identify any discrepancies sooner and potentially make them easier to resolve. A physical balance check of OxyNorm 10mg capsules complied with the balance in the register.

The pharmacy displayed a privacy notice and it had established processes in place for managing people's information confidentially. For example, it submitted its annual NHS Data Security and Protection (DSP) Toolkit annually as required. And it stored all personal identifiable information in staff only areas of the pharmacy. The pharmacy shredded confidential waste onsite.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. The RP had completed level two safeguarding training. And other team members had engaged in some learning on the subject. They did this through reading information and talking through how to manage a concern. The dispenser explained how her confidence in recognising concerns relating to dementia had grown. This was due to learning which had involved pharmacy team members becoming dementia friends through the Alzheimer's Society initiative. The pharmacy had access to contact information for local safeguarding agencies, in the event it needed to escalate a concern.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs qualified and skilled people to provide its services. It supports its team members through regular learning relevant to their roles. Pharmacy team members take part in regular conversations relating to risk management and safety. And they have the confidence to follow the pharmacy's feedback processes should they need to.

Inspector's evidence

On duty during the inspection was the pharmacy manager and a qualified dispenser. The pharmacy also employed two part-time medicine counter assistants. Both medicine counter assistants had completed extended training. This meant they could undertake stock management tasks such as putting away the dispensary order and date checking. The prescription collection and delivery service was provided by a company employed driver. The manager received some support when the dispenser was on leave from other dispensers within the company.

Pharmacy team members completed some continual learning related to their roles. For example, the dispenser discussed learning about dementia and attending smoking cessation training. Details of the pharmacists continual learning was documented. And this included learning relating to service and risk management. The pharmacy had a structured appraisal process. This involved an annual review of its team members performance and development. It did not set its team members specific targets to meet. The RP provided examples of how she used her professional judgement to support people who required advice and information.

Pharmacy team members were observed completing tasks with efficiency. They engaged well with people visiting the pharmacy by asking after people's health and wellbeing. The pharmacy had a whistle blowing policy. The dispenser confirmed she was happy to feedback any concerns to the manager in the first instance. And she understood how she could escalate concerns if required. The RP confirmed she could seek support from the superintendent pharmacist if needed. For example, to liaise about staff cover during holiday periods.

The pharmacy team members took part in regular discussions relating to patient safety and risk management. And the pharmacy manager produced a formalised patient safety report each month. This report clearly highlighted areas of priority each month. For example, the most recent areas of priority focussed on checking items during the bagging process and taking care with different formulations of the same medicine.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was open plan with seating provided to people wishing to wait for a prescription or a service. The consultation room was sign-posted, and it was used by pharmacy team members with people who required privacy. The room was a good size and it was professional in appearance.

The dispensary was a galley style. It was narrow, but pharmacy team members managed work space well. Work benches were free from excess clutter. And floor spaces were relatively clear. All items stored at floor level were stored safely by being pushed back against the wall. For example, medicine waste receptacles.

Pharmacy team members reported maintenance issues to the superintendent pharmacist. And local tradespeople were used to manage any concerns. There were no outstanding maintenance issues noted during the inspection. The pharmacy was clean and organised. Antibacterial soap was readily available at the pharmacy's sinks. The pharmacy had air conditioning. Lighting throughout the premises was sufficient.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services. And its team follow these procedures appropriately. People visiting the pharmacy receive advice to help them take their medicine safely. The pharmacy obtains its medicines from reputable sources. And it keeps its medicines safe and secure.

Inspector's evidence

The pharmacy was accessed through a simple push/pull door up a step from street level. Pharmacy team members could deploy a portable ramp in the event a person required assistance with access into the pharmacy. Details of the pharmacy's opening times and services were clearly advertised. It displayed details of national health campaigns which helped to engage people in conversation about their health and wellbeing. The pharmacy was currently advertising an antibiotic awareness campaign. The pharmacy team understood the requirements to signpost people to another pharmacy or healthcare provider if it was unable to provide a service.

The pharmacy had legally valid patient group directions (PGDs) for the supply of varenicline tablets and emergency hormonal contraception. It also had an up-to-date minor ailment scheme protocol. Supplies of medicines through the minor ailment scheme had reduced due to growing support to promote self-care. Pharmacy team members engaged well with people throughout the inspection. The RP was observed telephoning a surgery on behalf of a patient who required palliative care medication as the prescription called for a CD but did not include specific directions. The RP was calm and reassuring when speaking with the patient's representative over the telephone and confirmed she would manage the issue. And she provided clear details of the delivery service. The RP reflected on the outcomes of some of the pharmacy's services. For example, a person struggling with their medication regimen would be invited to have a Medicines Use Review (MUR). The RP explained how this had led to an assessment of the risks and benefits of offering to supply medicines in multi-compartmental compliance packs. People had started to enquire about the seasonal flu vaccination service. And the RP was in the process of preparing for the service. She explained how positive feedback about the convenience of the service was received.

The pharmacy had some processes for identifying people on high-risk medicines. The RP verbally counselled people on these medicines. But outcomes of these discussion were not recorded. The pharmacy team was aware of the requirements of the valproate Pregnancy Prevention Programme (PPP). And high-risk warning cards were available if required.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. The dispenser signed the prescription form to indicate her role in the dispensing process. The RP demonstrated the pharmacy's current medication labels which did not include 'dispensed by' and 'checked by' boxes. She explained the pharmacy had changed to a new clinical software provider and confirmed she had fed the issue back to the superintendent pharmacist. In lieu of these boxes, the RP signed the corner of each medication label to confirm that an accuracy check of the medicine had taken place. The pharmacy team kept

original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy ordered prescriptions for people upon their request. And it maintained an audit trail of these orders to help resolve any queries. The pharmacy maintained an audit trail for the prescription delivery service and people signed to confirm they had received their medication.

Each person on the multi-compartmental compliance pack service had an individual medication plan. This plan provided details of the person's medication regimen. And pharmacy team members used it to track changes to these regimens, following confirmation of the changes with the surgery team. The RP assembled and checked most packs herself. She explained how she assembled packs, covered them and took a break from the dispensing process. She then returned to check the pack later. And demonstrated how she applied additional checks of the contents against the backing sheet, prescription forms and original packaging during her accuracy checking process. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. And it supplied patient information leaflets at the beginning of each four-week cycle of packs. But backing sheets were not physically attached to the packs. This prompted a discussion relating to medicine labelling requirements and risks associated with using loose backing sheets.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated an awareness of the aims of the Falsified Medicines Directive (FMD). And were familiar with changes to medicine packaging as a result of FMD. But the pharmacy had yet to introduce scanners to support its team in meeting the requirements of FMD. The RP confirmed she had discussed FMD with the superintendent pharmacist, who had confirmed to her that no formal decision about which system to use had yet been made.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. The team followed a date checking rota which confirmed it was regularly identifying short-dated medicines. And pharmacy team members annotated the opening date on to bottles of liquid medicines. This allowed them to apply checks during the dispensing process to ensure the medicine remained fit for purpose. No out-of-date medicines were found during a random check of dispensary stock. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts through email. And it printed and retained details of actioned alerts.

The pharmacy held CDs in secure cabinets. Medicines were kept in a safe and orderly manner inside the cabinets. Date expired CDs and patient returned CDs were stored within the same bag inside the stock cabinet. But the individual packets were marked clearly. The pharmacy did not physically mark all CD prescriptions to help identify them. But pharmacy team members were observed applying vigilance when handing out assembled medicines. And the dispenser had a clear understanding of the validity period of a CD prescription, including prescriptions for CDs which did not require safe custody. The pharmacy's fridge was a good size for the amount of medication stored inside. The pharmacy did store some food and drink inside the fridge. Although not ideal, it had considered this risk and stored these items away from medicines. Temperature records confirmed the fridge was operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy's computers were password protected. And information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. The pharmacy stored assembled bags of medicines in the dispensary and out of the direct line of sight of the public area. Pharmacy team members used NHS smart cards to access people's medication records. And they used a cordless telephone handset. This helped to protect people's confidentiality as the pharmacy team member was able to move into the consultation room or to the back of the dispensary when using the handset.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included a separate measure for use with methadone. The RP calibrated the MethaMeasure machine each day as part of the set-up process. The pharmacy had access to a telephone support service and engineer support should the machine malfunction. The pharmacy had clean counting equipment for tablets and capsules, including a separate counting triangle for use when counting cytotoxic medicines. The pharmacy had the necessary equipment readily available to support the supply of medicines in multi-compartmental compliance packs. Its electrical equipment was clean, and wires were visually free of wear and tear. The RP reported the last electrical safety checks she could recall were approximately three years ago.

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.