General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: New Street Pharmacy, New Street, Dinnington, SHEFFIELD, South Yorkshire, S25 2EX

Pharmacy reference: 1039351

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

This community pharmacy is in the town of Dinnington in South Yorkshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides NHS services including Pharmacy First, blood pressure checks and the New Medicine Service (NMS). The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to people residing in care homes. And it offers a medicine delivery service to people.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 identifies and manages the risks for the services it provides. It keeps people's confidential information secure. And it generally keeps the records it must by law. Its team members conduct regular checks to help the pharmacy in maintain the required standards. Pharmacy team members understand how to recognise and report safeguarding concerns to help keep vulnerable people safe from harm. And they share learning and take action to reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had changed ownership at the end of July 2023. The superintendent pharmacist (SI) had implemented new standard operating procedures (SOPs) following this change of ownership. These were next due for review in July 2025. Pharmacy team members completed learning records to confirm they had read and understood the SOPs. On the morning of the inspection the responsible pharmacist (RP) was late for work. The team had not commenced any registrable activities and demonstrated a clear understanding of what they could not do before a pharmacist assumed the RP role. The pharmacy employed a pharmacy technician in an accuracy checking role (ACPT). The team demonstrated how pharmacists physically marked prescriptions to confirm they had completed a clinical check of a prescription prior to the ACPT completing final accuracy checks of medicines.

The pharmacy had processes for managing mistakes that were identified during the dispensing process, known as near misses. Pharmacy team members consistently reported these mistakes. And they used information within the reports to inform a monthly patient safety review. This review was documented for all team members to refer to. It looked at trends in mistakes and identified actions designed to reduce risk. For example, reviewing the stock location of medicines held in the dispensary. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a medicine to a person, known as a dispensing incident. The pharmacy reported incidents to the SI and through the NHS 'Learning from Patient Safety Events' portal. And there was evidence that the pharmacy acted appropriately to reduce risk following these events. Team members took turns completing regular checks of the pharmacy environment, record keeping and risk management processes. The checks identified any areas for attention required and showed how the pharmacy complied with legal and regulatory requirements.

The pharmacy had a complaints procedure. But it did not advertise how people could provide feedback or raise a concern about the pharmacy. A team member explained how they would manage a concern and how they would escalate a concern to the attention of the RP or SI if needed. Pharmacy team members had completed some learning to assist them in recognising concerns about vulnerable people. They had information available to support them in reporting a safeguarding concern. And they provided examples of raising concerns with other healthcare professionals to support people in taking their medicines safely.

Person identifiable information was held within staff-only areas of the premises and on password-protected computers. It disposed of confidential waste securely. The pharmacy had current professional indemnity insurance. The RP notice on display contained the correct details of the RP on

duty. And the RP record was generally completed in full, but occasional records did not show what time the RP had ceased their role. A sample of other pharmacy records examined mostly complied with legal requirements. There was some confusion about how the pharmacy held its private prescription register as both a handwritten register and a digital register was being kept. But neither register was completed in full. A discussion highlighted the need to keep one complete legal record of the private prescriptions dispensed. The pharmacy maintained running balances in the controlled drug (CD) register and completed full balance checks CDs against the register frequently. Random physical balance checks conducted during the inspection matched with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of people with the appropriate skills and knowledge to provide its services effectively. Pharmacy team members put patient safety first by engaging in regular shared learning to support the safe management of pharmacy services. They engage in some learning at work relevant to their current roles and they know how to raise concerns at work. But they do not always have the opportunity to rotate into new roles to expand their learning and development.

Inspector's evidence

The SI was the RP on duty, and they were supported by four qualified dispensers during the inspection. Another qualified dispenser joined the team towards the end of the inspection. The pharmacy also employed another dispenser, an ACPT, a trainee dispenser, a regular pharmacist, and a delivery driver. Cover for absences was managed within the team. The team was running a little behind with its workload. Team members felt this was due to the regular pharmacist being on leave. Team members worked to ensure that prescriptions for people waiting were prioritised. The SI worked regular shifts at the pharmacy and the regular pharmacists leave was covered by locum pharmacists, not all of whom were familiar with the pharmacy. The pharmacy encouraged its team members to promote its services. It did not set specific targets for providing its services.

Prior to the change in ownership of the pharmacy, another local pharmacy had closed. This had resulted in two pharmacy teams coming together within this one pharmacy to provide services. This had changed the scope of the services provided. Team members generally worked to complete specific tasks and they had not received the opportunity to learn more about each other's roles to support them in working effectively together. This meant there was some division in the team. The pharmacy kept evidence of the learning it shared with all team members to support the safe and effective running of the pharmacy, including regular checks of the pharmacy environment, and reviewing and learning from patient safety events.

One team member was enrolled on a GPhC accredited learning course relevant to their role. But other team members explained they were not aware of this. This potentially limited the support available to the trainee to help them develop their skills in working safely and effectively. The SI provided assurances that the trainee received support from the regular pharmacist. A discussion highlighted the benefits of all team members supporting each other's learning and development at work. Other team members completed some learning relevant to their roles. Learning in the past year had focussed on the requirements of the NHS Pharmacy Quality Scheme and learning to use a new patient medication record system.

The pharmacy had a whistle blowing policy and team members explained they would raise any concerns at work by bringing these to the attention of the regular pharmacist and escalating to the SI if needed. But they felt they were not always provided with details of an outcome after they provided feedback. The SI had sought some support from a professional human resources (HR) service. They explained this support was available to team members too. But team members were not aware of this. A discussion with the SI highlighted the importance of ensuring all team members knew how to access HR support.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard. It offers a professional environment for delivering its services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. Team members knew how to report maintenance concerns. Local tradespeople were used to manage any maintenance work required. The pharmacy was clean and generally tidy. Floor spaces were free from trip hazards. Lighting was bright and air conditioning helped to control the temperature all year round. Pharmacy team members had access to sinks equipped with appropriate hand washing materials.

The public area of the pharmacy was spacious and fitted with wide-spaced aisles and seating available for people waiting. Two consultation rooms were accessible from this area. The rooms were professional in appearance and offered suitable spaces for holding private conversations with people. The dispensary was accessed up a few steps to the side of the medicine counter. It was small for the services provided and some workbench space was taken up with baskets containing part-assembled medicines and medicines waiting to be checked. The team had enough space for completing labelling, dispensing, and checking tasks safely. A door leading from behind the medicine counter provided access to a substantial sized storeroom. Part of the storeroom was fitted out as a dispensary and provided protected space for completing tasks for the multi-compartment compliance pack service and some dispensing tasks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from recognised suppliers, and it stores these safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply to people. They provide relevant information when supplying medicines to people to support them in taking their medicines safely. And overall, they follow safe practices and show how they consider risk when dispensing medicines.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening times. And it displayed some helpful information for people about its services. Pharmacy team members had good knowledge of the local area. They understood the requirement to signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide. Team members had access to appropriate information to support them in delivering the pharmacies services. For example, SOPs, service specifications, clinical pathway flowcharts and patient group directions for the Pharmacy First service.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind plastic screens throughout the public area. Team members, including the RP had an unobstructed view of the public area due to the raised height of the dispensary. A team member explained how they would support a person requesting a P medicine and team members were observed asking appropriate questions to ensure a medicine was suitable for a person to take before processing a sale. The pharmacy team routinely identified some higher-risk medicines during the dispensing process. And it had processes to prompt recording of interventions made by the pharmacist. These interventions were generally recorded on a paper intervention record. Team members had knowledge of dispensing requirements when supplying medicines subject to pregnancy prevention programmes (PPPs). The RP discussed the checks they would make when supplying medicines to people in the at-risk group. And they took the opportunity to discuss recent updates to the valproate PPP requiring them to provide counselling to men.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form, and it helped the team manage workload priority. Pharmacy team members signed their initials in the 'dispensed-by' and 'checked-by' boxes on medicine labels. This provided a dispensing audit trail and helped to direct a query should one arise. The pharmacy kept a record of the medicines it owed to people. Team members made regular checks of medicines which were out of stock to help inform people of the need to return to the GP for an alternative before they ran out of medicine. The pharmacy kept an audit trail of the medicines it delivered to people's homes and of the medicines it delivered to care homes.

The pharmacy provided medication administration records (MARs) when dispensing medicines to people residing in care homes. A team member demonstrated the records used to support the team in dispensing regular medicines to people residing in homes prior to the beginning of the cycle start date. They had a process for informing care home teams of queries and missing items. But details of this communication were not always kept. Care homes ordered their own repeat prescriptions, but on

occasion delays in doing this heightened pressure on the pharmacy team and meant pharmacy team members deviated from standard operating procedures. For example, they assembled some medicines for dispensing ahead of the clinical check of a prescription taking place by a pharmacist. They had considered the risks of working in this way and could clearly identify prescriptions requiring clinical checks ahead of accuracy checks taking place. The pharmacy processed a number of urgent prescriptions each day for care homes. Team members identified how prescriptions for regular medicines from an interim care unit heightened pressures on the team. This was due to the medicines being required urgently, and sometimes assembled into multi-compartment compliance packs ahead of a person being discharged back to their own home. Team members received some instructions from the care home about tasks it was required to complete. But these tasks had not been formally agreed between the pharmacy and care home to support the pharmacy in planning this workload effectively.

Team members used monitoring sheets and individual records to support them in supplying medicines in multi-compartment compliance packs. They checked changes to medicine regimens with GP surgery teams. They recorded these changes clearly on people's individual records. And they kept information about the change within the record, such as hospital discharge notes. The majority of people ordered their own prescriptions when receiving their medicines in this way. Because of this, the team provided some reminders to people on notes attached to bag labels to support them in marking the date their prescription was due to be ordered on their calendar at home. A sample of compliance packs found clear descriptions and dispensing audit trails on the attached backing sheets. The pharmacy routinely provided patient information leaflets at the beginning of every four-week cycle of compliance packs. And the team monitored the collection of compliance packs to help ensure people were collecting their medicines as required.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner within their original packaging. It held its CDs in secure cabinets, and it held medicines requiring cold storage in pharmaceutical fridges, equipped with thermometers. The pharmacy kept temperature records for the fridges. There were occasional gaps in these records but records available showed the operating temperature of the fridges remained within the required range of two and eight degrees Celsius.

The team recorded the checks it made to ensure medicines were safe to supply to people. These checks included completing routine date checking tasks and actioning drug alerts and medicine recalls in a timely manner. A random check of dispensary stock found no out-of-date medicines. Team members annotated bottles of liquid medicines when opening them to show the opening date and details of any shortened expiry date. The pharmacy had appropriate medicine waste receptacles, CD denaturing kits and sharps bins available. There was a large number of medicine waste bins awaiting collection. A team member explained this was due to residential homes returning medicine waste to the pharmacy. The bins were held away from stock medicines and assurances were provided of regular collections taking place.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it required to provide its services. And its team members manage and use equipment appropriately.

Inspector's evidence

Pharmacy team members had access to common pharmacy reference resources which they generally accessed digitally. They also used the internet to help them obtain up-to-date information when providing advice to people. Team members used password-protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines in a retrieval area which could not be seen from the public area.

Pharmacy team members had a range of equipment from recognised manufacturers for providing its consultation services. Equipment for measuring and counting medicines was standardised and separate equipment was used when measuring higher-risk medicines to avoid any risk of cross contamination. Team members cleaned equipment between use, and it checked equipment regularly to ensure it was free from wear and tear. Electrical equipment was in working order and portable appliance testing had taken place within the last six months.

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.