

Registered pharmacy inspection report

Pharmacy Name: Dinnington Pharmacy, Dinnington Surgery, New Street, Dinnington, SHEFFIELD, S25 2EZ

Pharmacy reference: 1117254

Type of pharmacy: Community

Date of inspection: 20/02/2020

Pharmacy context

This community pharmacy is in Dinnington, a town between Rotherham and Sheffield in South Yorkshire. The pharmacy is open extended hours over seven days a week. It 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 some people with their medicines in multi-compartment 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

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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	2.5	Good practice	The pharmacy encourages feedback from its team members. And it demonstrates how it listens to and responds to feedback to help ensure people receive their medicines in a timely manner.
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 generally identifies and manages the risks associated with its services. It keeps people's private information secure. And it advertises and responds to feedback about its services appropriately. Pharmacy team members understand how to recognise, and report concerns to help protect the wellbeing of vulnerable people. They act openly and honestly by sharing information when mistakes happen during the dispensing process. And they act to reduce risk following these types of mistakes. The pharmacy generally keeps all records it must by law up to date. But some minor gaps in some of these records may make it more difficult for the pharmacy to manage a query should one arise.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These were seen to be reviewed at two yearly intervals. The next review was recorded as being due in February 2020. And the responsible pharmacist (RP), who was the superintendent pharmacist (SI) confirmed he was aware that SOPs were due for review. SOPs covered controlled drug (CD) management, RP requirements, dispensary processes and pharmacy services. They included the roles and responsibilities of pharmacy staff. And most pharmacy team members had signed those relating to their roles. A trainee dispenser was coming to the end of her three-month induction period at the pharmacy. She had yet to read and sign the procedures. This could mean a delay in identifying some learning opportunities. The trainee explained what tasks could not be completed if the RP took absence from the pharmacy. All team members were observed working in accordance with dispensary SOPs during the inspection.

The dispensary was split between two rooms. At the beginning of the inspection all available work bench space in the back room of the dispensary was occupied with baskets of assembled medicines waiting to be checked. Pharmacy team members explained the SI had been undertaking appraisals with each member of the team and as such managed workload had built up. Once the SI began checking this backlog the work benches cleared. And team members demonstrated how they used separate areas of the dispensary for managing labelling, assembly and accuracy checks.

The pharmacy had a near-miss error reporting procedure. The near-miss record for February 2020 was displayed. Records made included contributory factors and some further learning. The pharmacy had a procedure for reporting dispensing incidents. The SI explained he had not had to manage an incident since taking over as superintendent pharmacist around 18 months ago. But he explained clearly how he would manage, report and investigate an incident. The team were observed sharing information relating to a near miss with the surgery team during the inspection. This was due to a person being given the wrong prescription at the surgery. The pharmacy's checking processes for confirming names and addresses when handing out prescriptions had identified the mistake before the medication was transferred to the person.

A trainee dispenser took a particular interest in patient safety. And she led a monthly review of near misses with the support of the SI. But records associated with the monthly review process were not physically available in the pharmacy on the day of inspection. The team member explained she had taken the records home to work on an annual patient safety report. Information taken home was confirmed to be general data and did not include any personal identifiable information. The team

member demonstrated a 'WhatsApp' group which contained photographic evidence of the pharmacy's most recent patient safety report. She explained the pharmacy owner asked all pharmacies to submit evidence of the report to him each month to help ensure pharmacies were following the company's processes. Pharmacy team members demonstrated actions they had taken to reduce risk following the monthly patient safety review. For example, they used flash notes on people's medication records and had a printed note at a work station in the dispensary to reduce the risk of labelling and handout errors to people with similar names and addresses. And they had started to look at stock layout in the dispensary and had separated some 'look-alike and sound alike' medicines to help reduce the risk of a picking error occurring.

The pharmacy had a complaints procedure. And this was advertised within the pharmacy's practice leaflet which was available to give to people. A member of the team explained how she would take details of a concern and escalate it to the RP, if she was not able to resolve the matter. The pharmacy also advertised feedback through a survey about waiting times and people's experience. The survey form was available at the medicine counter and people could post their response in a box to remain anonymous. A team member explained how a bell had been fitted at the medicine counter to allow people to get the team's attention if they were working in the back room of the dispensary.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice was updated to reflect the correct details of the RP on duty as the inspection began. Entries in the RP record generally complied with legal requirements. A couple of missed sign-out times were observed in the sample of the record examined. The Prescription Only Medicine (POM) register generally complied with legal requirements. Occasional dates were observed to be missing from some entries in the register. And the pharmacy had not always recorded details of emergency supplies made through the Community Pharmacist Consultation Service (CPCS) in the register. The pharmacy kept records for unlicensed medicines in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy maintained running balances in its CD register. And it checked these balances against physical stock weekly. CD record keeping required some improvement as some page headers were missing, footnotes following mistakes were not always dated. And the pharmacy did not always enter the address of the wholesaler when entering receipt of a CD into the register. A physical balance check of Zomorph 60mg capsules completed during the inspection complied with the balances recorded in the register. The pharmacy kept a patient returned CD register. Some returns received the week of inspection had not been entered into the register. Pharmacy team members explained they normally entered details of returns immediately. And the records supported this practice. A member of the team acted to enter the returns in the register immediately.

The pharmacy stored people's personal information in staff only areas of the pharmacy. A locked cabinet within the GP practice was used for storing some archived records. Only pharmacy team members had access to this cabinet. Pharmacy team members demonstrated how their dispensing process kept people's information safe and secure. All team members had completed some learning relating to confidentiality requirements. The pharmacy had submitted its latest NHS Data Security and Protection toolkit as required. The pharmacy secured its confidential waste in bags. And this was disposed of centrally by the company.

The pharmacy had procedures and information relating to safeguarding vulnerable people. Contact information for safeguarding teams was readily available for its team members to refer to. Pharmacy professionals had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). And some other team members confirmed learning associated with

safeguarding which ranged from reading SOPs and local guidance to e-learning. A pharmacy team member provided an example of how she would recognise and report a concern. And the team had recorded details of an intervention made with the surgery regarding a potentially vulnerable person on their medication record.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has team members with the appropriate skills and qualifications to provide its services safely and effectively. It encourages continual learning and supports its team members in developing their roles. Pharmacy team members show how they share learning. And they demonstrate respect for each other. They understand how to raise a concern and provide feedback if needed. The pharmacy encourages feedback from its team members. And it demonstrates how it listens to and responds to feedback to help ensure people receive their medicines in a timely manner.

Inspector's evidence

On duty during the inspection was the SI, a pharmacy technician, a dispenser and two trainee dispensers. The pharmacy also employed a delivery driver. And a full-time regular locum also worked at the pharmacy. A small number of other locums regularly supported services to cover days off and leave. There was some flexibility within the team to cover periods of absence. There were some occasions when a pharmacist completed labelling, assembly and accuracy checks of a medicine. Pharmacists were encouraged to self-check with care and take mental breaks between assembly and the accuracy check of a medicine.

Pharmacy team members completed some ongoing learning associated with their roles through e-learning modules and reading pharmacy journals and newsletters. A sample of training records were demonstrated. There was no protected learning time for this continual learning. But team members enrolled on accredited training courses did receive protected learning time at work. The pharmacy had a structured appraisal process to support its team members learning and development. And pharmacy team members confirmed they could feedback any concerns or ideas as part of this process.

Pharmacy team members on duty were observed working well together throughout the inspection. A trainee member of the team confirmed she had felt well supported since joining the team. And was confident in asking questions to support her in completing tasks safely and efficiently. The SI explained there was no specific targets for providing services. Pharmacists were encouraged to speak to people about their health and wellbeing and use opportunities to complete advanced services when able. The pharmacy team members supported pharmacists by identifying people who were eligible for services during the dispensing process.

The pharmacy team had a regular patient safety review meeting each month to share learning. But any notes relating to these meetings were not available on the day of inspection. General feedback opportunities were taken through informal conversations during the working day. The pharmacy had a whistleblowing policy. Pharmacy team members were confident at explaining how they would share concerns at work. And they knew how to escalate a concern if required. A member of the team explained how the pharmacy's training provider regularly spoke to her about feedback mechanisms. Pharmacy team members explained the SI was receptive to their ideas and provided examples of how the pharmacy had used their feedback to inform the way in managed its services. For example, a team member had introduced a 'change of medication' request form. The form was used to notify surgeries of stock issues caused by manufacturing delays. And it meant the pharmacist could suggest available alternatives. This reduced the risk of a person returning to the pharmacy with a prescription for another

medicine affected by supply delays.

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 maintained to a respectable standard and it was secure. Pharmacy team members reported maintenance issues to the SI and they confirmed issues were managed in a timely manner. The pharmacy was clean. Floor spaces were clear of trip hazards. Antibacterial handwash and towels were available at the dispensary sink. But a designated hand washing sink in the consultation room was not easily accessible. Lighting was sufficient throughout the premises. The pharmacy had suitable heating arrangements. And team members could open windows in summer months to aid ventilation.

The public area of the pharmacy consisted of the medicine counter. There was some designated shared seating available for people to sit and wait for their prescription. The consultation room provided a suitable space for holding private consultations. And it could accommodate a wheelchair. But due to limited storage space in the pharmacy, it was used to store folders and other items which did distract from its professional appearance. The room was kept secure between use to avoid the risk of unauthorised entry.

The dispensary was an appropriate size for the level of activity undertaken. It was split between two rooms. The front room of the dispensary included the medicine counter. And as such the team applied vigilance to the activities carried out in this area. They utilised work bench space in the back room of the dispensary for the majority of tasks associated with dispensing services. There was a designated space to the side of the dispensary for completing tasks associated with the multi-compartment compliance pack service. Staff facilities were provided in shared areas of the GP surgery.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy promotes its services. And it makes them accessible to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. The pharmacy has procedures to support the pharmacy team in delivering its services. But there are occasions when the team members work outside of these procedures when assembling medicines in multi-compartment compliance packs. This could mean they are not always working in the safest and most effective way. People receive information to support them in taking their medicines. But the pharmacy doesn't always utilise its resources to provide additional support to people taking high-risk medicines.

Inspector's evidence

The pharmacy was accessible from street level. The surgery's main door provided access during core opening times. And a well sign-posted second entrance was used during the pharmacy's extended opening times. The pharmacy was located to the left side of the surgery's waiting area and was clearly signposted. The pharmacy displayed details of its opening times and services. It also advertised some information relating to national health campaigns close to its designated waiting area.

Pharmacy team members were aware of signposting requirements should the pharmacy be unable to provide a service or supply a medicine. People attending the pharmacy with queries about their medicines or health were appropriately referred to the pharmacist when required. And the SI was observed providing information about the use of both prescribed and over-the-counter medicines during the inspection. People on high-risk medicines were not counselled every time they received their medication. This meant there could be some missed opportunities to support people in using their medicines safely. The SI explained how the pharmacy would prioritise people on higher risk medicines and with chronic diseases for services such as Medicines Use Reviews (MURs). Pharmacy team members were aware of the requirement to refer a prescription for valproate to the RP, if it was prescribed to a female. And the pharmacy had engaged in some recent NHS Pharmacy Quality Scheme (PQS) audits relating to managing high-risk medicines. The pharmacy had warning cards associated with the valproate pregnancy prevention programme (PPP) available to issue to people in the high-risk group. And a discussion took place about the requirement to issue these cards each time valproate was dispensed to a person within this group.

The pharmacy technician led the multi-compartment compliance pack service. People on this service ordered their own repeat prescriptions due to NHS restrictions on pharmacy's ordering on behalf of people. The pharmacy technician demonstrated how the pharmacy attached large print prompt sheets to week three of each four-week cycle of packs. This prompt informed people of the need to order their next cycle of prescriptions. The pharmacy had an unconventional way of assembling packs. It assembled each pack and left it with a basket containing the original packaging, prescription forms, patient profile record and backing sheets. The RP then attached the backing sheet to the pack during the accuracy check of the medicine. This practice could increase the risk of a mistake occurring should the wrong backing sheet be attached to a pack in error. And a discussion took place about managing all risks associated with the service in accordance with the pharmacy's SOPs. Each person receiving their medicines in this way had a profile sheet in place. And details of changes to medication regimens were recorded. A sample of assembled packs included full dispensing audit trails. The pharmacy provided

descriptions of the medicines inside the packs, to help people recognise them. And it issued patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The delivery driver obtained signatures from people when delivering medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The pharmacy had yet to take any steps to begin implementing processes to comply with the requirements of the Falsified Medicines Directive (FMD). Team members had limited knowledge of FMD. But recognised changes to medicine packaging due to the introduction of tamper proof seals. The SI had discussed FMD with the owner. But wasn't aware of when a FMD compliant system would be available in the pharmacy.

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. It stored medicines in the dispensary in an organised manner and within their original packaging. Pharmacy team members followed a date checking rota to support regular checks across all pharmacy stock. A random check of dispensary stock found no out-of-date medicines. Pharmacy team members annotated the opening date on liquid medicines with a shortened shelf life once opened.

The pharmacy had secure cabinets for the storage of its CDs. Medicines inside the cabinets were not always stored in an orderly manner as space within the cabinets was limited. For example, stock boxes of Zomorph 60mg capsules were found to be stored in both cabinets. Two assembled CDs related to prescriptions which had been written in excess of 28 days ago. These were brought to the direct attention of the SI for appropriate management. The pharmacy did have designated storage space for assembled CDs, out-of-date CDs and patient returns within the cabinets. The RP was observed checking details of assembled CDs against the prescription prior to hand out. CD prescriptions were highlighted. And team members were aware of the requirement to check the validity period of all CD prescriptions prior to handing medicines out to people. The pharmacy's fridge was clean and stock inside was stored in an organised manner. A sample of temperature records found one missed entry. But temperatures either side of these gaps confirmed that it was operating between two and eight degrees Celsius as required.

The pharmacy received drug alerts and recalls by email. And the team demonstrated how these alerts were read and actioned. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

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. This included the British National Formulary (BNF). Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy computers were protected from unauthorised access due to the layout of the premises. One computer in the front area of the dispensary faced towards the medicine counter. Information displayed on the screen at the time of inspection could not be read from the public area. Pharmacy team members used passwords and NHS smart cards to access people's medication records.

The pharmacy held assembled bags of medicines within the dispensary. This protected people's private information on prescriptions and bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets. This meant they could move out of ear shot of the public area when speaking to a person over the telephone. This helped to protect the person's privacy.

The pharmacy had a blood pressure machine and glucometer available. But the SI explained the equipment was no longer used as screening services were offered at the GP surgery. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. It used separate cylinders for measuring methadone. And clean counting equipment for tablets and capsules was available. Its electrical equipment and cables were free from wear and tear.

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.