General Pharmaceutical Council

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: 08/11/2022

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	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 mainly manages the risks associated with its services appropriately. It keeps people's confidential information secure and it advertises how people can provide feedback about its services. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in conversations following the mistakes they make during the dispensing process. This helps to reduce the risk of similar mistakes being made. Team members make appropriate entries within the pharmacy records required by law. But they are not always able to retrieve records quickly. This may lead to some delays if there was a query about the supply of a medicine.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) designed to support its safe and effective running. These included SOPs relating to the responsible pharmacist (RP) role, controlled drug (CD) management and pharmacy services. The SOPs had last been reviewed in November 2020 by the pharmacy's previous superintendent pharmacist (SI). The RP on duty had commenced in the role of SI in September 2022, and confirmed that they would shortly be undertaking a full review of the pharmacy's SOPs. Pharmacy team members had signed SOPs relevant to their role to confirm they had read and understood them. And they were confident in discussing and demonstrating different tasks. A trainee team member explained clearly what tasks could not take place if the RP took absence from the premises.

A pharmacy team member described how mistakes made and identified during the dispensing process, known as near misses, were brought to the attention of the team member involved. The team member then acted to correct their mistake. The team provided examples of how it acted to reduce risk following conversations about these types of mistakes. For example, it had separated medicines that looked alike and those that had similar names. But team members did not always take the opportunity to record details of their near misses to help inform regular reviews of the types of mistakes being made. This meant that it was more difficult for the team to measure the effectiveness of the actions it had implemented. And it potentially meant that trends in mistakes were not picked up and shared with the team. The pharmacy team were confident in explaining how the previous SI had acted to report dispensing incidents electronically. But records of reporting were not available. The SI confirmed his approach to managing and reporting dispensing incidents. And the team provided evidence of how it acted to reduce risk following these type of events. For example, it had reviewed the stock location and had acted to separate risperidone and ropinirole following an incident involving the wrong medicine being supplied to a person.

The pharmacy had a complaints procedure, and this was advertised to members of the public. Team members understood how to manage feedback and escalate concerns to the attention of a pharmacist when required. The pharmacy had recently experienced a rise in feedback relating to stock issues in the supply chain. The pharmacy used a good range of wholesalers to increase the likelihood of stock being available. And the SI spoke regularly with GPs to help keep them informed of out-of-stock medicines subject to supply problems. The pharmacy had information governance procedures to support its team members in managing people's confidential information securely. It transferred its confidential waste to designated waste sacks. These sacks were collected for secure disposal on a regular basis. Team

members were observed acting with care to protect people's confidentiality. The pharmacy had procedures relating to safeguarding vulnerable adults and children. The SI had completed safeguarding learning to support them in their role. And other team members had read procedures and completed learning on the subject during their apprenticeship programme. A team member demonstrated their awareness of how to recognise and report safeguarding concerns to the RP on duty. And the pharmacy had contact information for local safeguarding agencies to support the team in escalating these kind of concerns.

The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed was changed as the inspection began to reflect the correct details of the RP on duty. The RP record was generally maintained in accordance with requirements. There were a few occasions where RPs did not sign-out of the register at the end of their shift. The pharmacy kept its private prescription register in accordance with legal requirements. But there was evidence that it occasionally supplied some medicines against a copy of the private prescription. And it didn't have a robust process to ensure it received the original prescription within a timely manner. A discussion took place about the risks associated with potentially not receiving the original prescription. And the SI acknowledged the need to have a process in place to chase and reconcile copies against the original prescription on these rare occasions. The pharmacy maintained its CD register with running balances. It generally completed balance checks of physical stock against the register monthly. Entries within the register largely complied with legal requirements. But the pharmacy did not always record the address of the wholesaler in the register when entering the receipt of a CD and page headers were not always completed as required. The pharmacy had a patient returned CD destruction record. And this was maintained to date. The pharmacy team was unsure where it stored records related to the supply of unlicensed medicines, and as a result these were not available for inspection. The SI was actively making enquiries to try and locate these records. And had set up a new filing systems for the pharmacy records to help ensure this did not happen again.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well. Pharmacy team members demonstrate enthusiasm for their roles and they engage in some continual learning to support them in delivering the pharmacy's services. They take part in conversations designed to minimise risk. And they are confident in sharing their thoughts and ideas at work.

Inspector's evidence

The SI was supported by a trainee dispenser and two qualified dispensers during the inspection. A delivery driver, and a regular locum pharmacist also worked at the pharmacy. Locum pharmacists covered the remaining opening hours. The pharmacy team reported that it had been short staffed following a team member leaving in September 2022. A new full-time apprentice was due to start the week after the inspection and a part-time trainee team member was also due to start. The pharmacy's business contingency plan had been tested during the pandemic when multiple team members had needed to isolate. This had seen team members from other local pharmacies within the wider ownership group support the pharmacy. And the SI confirmed that the team was able to reach out for support from these pharmacies if needed. Despite being exceptionally busy the team was coping with its workload. Pharmacy team members were observed working quietly and with care to support them in delivering a safe and effective dispensing service. The pharmacy did not set specific targets for its team members to meet.

The trainee dispenser was enrolled on an apprenticeship programme. They confirmed they received the appropriate learning time to support them in their role. And they were progressing well through their GPhC accredited training course. The dispensers had not had the opportunity to engage in regular structured learning following the completion of their training course due to workload pressures. But they demonstrated a positive attitude to learning and it was clear that they continually sought out information to support them in their roles. For example, a conversation during the inspection led a dispenser to research a new insulin pen recycling scheme launched by the manufacturer. Pharmacy team members engaged in regular discussions related to the delivery of services and patient safety. But they did not record the outcomes of these discussions. This meant some learning opportunities may be missed. The pharmacy had a whistleblowing policy and its team members understood how to raise concerns at work. They provided examples of how recent feedback had led to positive changes to improve the efficiency of the dispensing process. For example, following feedback from one team member, a fridge used to hold bags of assembled medicines was located in the front dispensary to support team members in handing out medicines in a timely manner.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and maintained to an acceptable standard. They provide an appropriate space for the delivery of healthcare 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 maintained to a respectable standard and it was secure. There was a process for pharmacy team members to report maintenance issues. The pharmacy was generally clean, there was some limescale build-up around the dispensary sink. Antibacterial handwash and towels were available at this sink. And there was a designated hand washing sink available in the consultation room. 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. The counter had robust plastic screening fitted to help support its team members manage the risk of delivering pharmacy services during a pandemic. The consultation room provided a suitable space for holding private consultations. The room was kept secure between use to avoid the risk of unauthorised entry. The dispensary was small for the volume of items dispensed. It consisted of two rooms and the team effectively split tasks over the extended opening hours to support it in managing space. Pharmacy team members could access staff facilities in shared areas of the GP surgery. The pharmacy also had access to storage cabinets within the surgery. It used these to store dispensary sundries and spare equipment. And the cabinets remained locked between access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services. And it makes them accessible for people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. The pharmacy has procedures to support the team in delivering its services. But there are occasions when its 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.

Inspector's evidence

The pharmacy was clearly signposted and accessible from street level. It displayed details of its opening times and services. It also advertised some information relating to national and local 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. Activity at the medicine counter was busy throughout the inspection, with many requests for advice relating to minor ailments, and common health conditions. Team members were observed referring to the pharmacist when needed.

The pharmacy did not promote self-selection of any medicine. It stored both General Sales List (GSL) and Pharmacy (P) medicines behind the medicine counter. And pharmacists could supervise activity taking place at the medicine counter with ease. A team member demonstrated good knowledge of requirements of the valproate Pregnancy Prevention Programme (PPP). They explained how the pharmacy would safely make a supply of valproate to a person in the at-risk group. They discussed checks associated with the supply of other higher-risk medicines with confidence. And the team provided evidence of pharmacists recording some interventions for higher-risk medicines, including valproate on people's medication records. This process helped to support continual care. The pharmacy actively promoted the NHS New Medicine Service (NMS) and the SI reflected on the positive outcomes from this service. For example, the service had provided clarity to a person recently discharged from hospital about the long-term medicine regimen they would be following.

People receiving their medicines in multi-compartment compliance packs ordered their own repeat prescriptions due to NHS restrictions on pharmacies ordering on behalf of people. But some people struggled with remembering to order their prescriptions on time, and this sometimes caused increased workload pressure in the pharmacy to ensure people were not left without their medicine. The pharmacy team was in the process of working with GPs to identify people receiving their medicine in compliance packs, who may benefit from the repeat dispensing service. The team used the PMR to support the supply of medicines in compliance packs and to record changes to medicine regimens. A team member assembled each compliance pack and left it with a basket containing the original packaging, prescription forms, and backing sheet. But pharmacists attached the backing sheet to the pack during the accuracy check of the medicine. This was an unusual process and did not reflect the details recorded in the pharmacy's SOPs for dispensing medicines. As the backing sheet 'label' in this case was not applied during the assembly process. A discussion highlighted how this process had the potential to increase the chance of a mistake being made. 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. It held part-assembled workload in a designated area of the dispensary, and prioritised the completion of these prescriptions following stock orders arriving. The delivery driver used a smartphone application to track the status of the medicine deliveries they made. And pharmacy team members had access to a copy of the delivery route to help them in answering any queries they received.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in the dispensary in an organised manner and within their original packaging. The pharmacy had secure cabinets for the storage of its CDs. The team was actively working to bring its stock levels of these medicines down to help with storage space. And it generally stored medicines inside the cabinets in an orderly manner. There was designated storage space for assembled CDs, out-of-date CDs and patient returns within the cabinets. There was a need for the SI to organise an authorised witness visit to destroy some out-of-dates and some evidence associated with a breakage of a liquid medicine. The pharmacy highlighted prescriptions for CDs and it stored CDs and cold chain items in clear bags to prompt additional checks during the handout process. The pharmacy had two fridges; both had a thermometer available for monitoring the storage temperature of medicines inside them. But the probe for one monitor was not correctly placed inside the fridge and because of this the readings could not be relied upon as an accurate record. The opportunity was taken to support the team by sharing common practice for securing the probe and placing it in a suitable location within the fridge to provide an accurate reading. And the readings were checked at several points throughout the inspection to ensure the fridge was operating between two and eight degrees Celsius. The pharmacy was recording only one of the fridge temperatures up until the inspection, a record for the second fridge was set up during the inspection. And a discussion took place about the importance of maintaining these records.

Pharmacy team members reported completing regular date checks of medicines. But there was no record demonstrated to support this process. 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 received drug alerts and recalls by email. And these were read and actioned. The pharmacy had medical waste bins available to support the team in managing pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members act with care by using the pharmacy's equipment in a way which protects people's confidentiality. They have access to the necessary equipment to support them in providing the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). The SI had provided team members with a laptop computer to support access to the internet for tasks such as ordering medicines. They used password-protected computers and used NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It 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 to protect their privacy.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. The pharmacy had separate equipment available for counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. The pharmacy's current blood pressure machine did not have any markings indicating the brand of model number of the machine. And an accompanying manual did not include this information either. The team was using this machine to provide the NHS hypertension case-findings service. But due to the lack of information available it could not be sure the machine was included on the approved list of monitors published by the British and Irish Hypertension Society. A second machine which was on this list was available for use, but had yet to be used. The SI confirmed the machine would be used to deliver this service moving forward. Electrical equipment was in working order and cables and plugs were visibly 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.