General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dalton Pharmacy, Valley Health Centre, Saville Street, Dalton, Rotherham, South Yorkshire, S65 3HD

Pharmacy reference: 9010219

Type of pharmacy: Community

Date of inspection: 04/01/2024

Pharmacy context

This community pharmacy is in a health centre in a residential area of Rotherham in South Yorkshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a seasonal flu and COVID vaccination service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some 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

Overall, the pharmacy effectively identifies and manages the risks associated with providing its services. It mostly keeps the records it needs to by law. And it keeps people's confidential information secure. Pharmacy team members know how to respond to feedback. And they are supported in recognising and reporting concerns to protect potentially vulnerable people. They behave openly and honestly by sharing learning and through acting to reduce risk following the mistakes they make when dispensing medicines.

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. Team members explained they still had to read and sign these as the pharmacy had been short-staffed following the change in ownership. They provided details of the training they had received following the change in ownership to support them in continuing to work safely. And they demonstrated how some of the tasks they undertook had changed under the new ownership. They had recently identified a plan to complete the formal training records for the SOPs. Pharmacy team members demonstrated a good understanding of their job roles and had a clear understanding of their responsibilities. For example, the accuracy checking pharmacy technician (ACPT) demonstrated how the responsible pharmacist (RP) would record the clinical check of a prescription clearly on the prescription form. And they felt confident in referring queries to the pharmacist when accuracy checking medicines. A dispenser discussed their role and the tasks they could not complete if the RP were to take absence from the pharmacy.

The pharmacy had processes for managing mistakes that were identified during the dispensing process, known as near misses. Following a mistake being identified, team members checked their work again and corrected their work. They recorded some near misses on personal record sheets that prompted both individual and shared learning. And this learning was documented alongside entries. Team members demonstrated the actions they took to separate medicines with similar names, and those in similar packaging. But they acknowledged they did not always record a near miss during busier periods. A discussion highlighted the benefits of recording all near misses to help inform the pharmacy's ongoing approach to managing risk. 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 RP reported incidents directly to the SI. And an incident report was submitted through the NHS 'Learning from Patient Safety Events' portal. The pharmacy retained copies of incident reports which clearly highlighted shared learning following these types of mistakes.

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 provided examples of how the team managed feedback. This included escalating a concern to the SI if needed. Pharmacy team members had completed some learning to assist them in recognising and reporting safeguarding concerns under the previous pharmacy ownership. They had resources available to them to support them in reporting a concern. This included information to support a person experiencing domestic violence seeking use of a safe space within the pharmacy. The pharmacy delivery driver discussed how they remained vigilant to

safeguarding concerns when delivering medicines to vulnerable people. And they reported any concerns they had to the pharmacy team.

The pharmacy protected people's personal information by holding it within staff-only areas of the premises and on password-protected computers. It held confidential waste safely and disposed of this securely. The pharmacy had current indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. RPs signed into the RP record as required. But they did not routinely sign out of the record at the end of the working day. The pharmacy held records of the unlicensed medicines it dispensed with full audit trails showing who the medicine was supplied to as required. A sample of records made in the private prescription and controlled drug (CD) register met legal requirements. The CD register was maintained with running balances. And pharmacists completed full physical balance checks of stock against the register regularly. A random physical balance check of a CD completed during the inspection matched the balance recorded in the CD register. The pharmacy held a record of the patient-returned CDs it received. And it recorded these returns at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well to provide its services. Team members engage in learning relevant to their roles. And they are keen to share and implement their ideas to support the efficient delivery of the pharmacy's services.

Inspector's evidence

The RP on duty was a regular locum pharmacist. They were supported by an ACPT and two qualified dispensers. A pharmacy technician, a delivery driver and another dispenser also worked at the pharmacy. And the pharmacy had very recently filled the remaining vacancy with a qualified dispenser. The team reflected on the previous few months which had seen workload pressure increase due to difficulties in recruiting to vacancies and some absences due to leave. Team members had worked hard to get through this period and spoke positively about the future. They used a board in the dispensary to identify daily tasks to help keep them on track. And they had recently implemented an effective system to support them in managing a small backlog of work from the busy bank holiday period. They had also developed a rota to ensure all team members rotated tasks and kept up to date with their knowledge and skills when working in different areas of the pharmacy. Pharmacy team members felt supported in their roles and they were confident in providing feedback to the SI. They explained the SI occasionally worked at the pharmacy and kept in touch with them by telephone, email, and messages between visits.

All team members were qualified in their roles. They reported that learning following the change in ownership had focussed on the new patient medication record (PMR) system and making minor changes to the way the team managed their workload. The SI had discussed an upcoming NHS pharmacist-led service with the team. And team members had started to think about how this would change their roles. For example, the ACPT had discussed taking on more accuracy checking responsibilities now the pharmacy was fully staffed. Pharmacy team members were not required to meet specific targets. The RP explained they were actively encouraged to engage in pharmacy services and clearly demonstrated how they applied their professional judgement when working.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and maintained well. It provides a professional environment for delivering healthcare services. People using the pharmacy can speak to a member of the team in a private consultation room.

Inspector's evidence

The pharmacy was secure and well maintained. Team members knew how to report maintenance concerns and confirmed there were no current maintenance issues. The pharmacy was clean and organised. Lighting was bright and air conditioning helped to provide an ambient temperature throughout the year. Team members had access to sinks equipped with antibacterial hand wash and paper towels.

The public area was fitted with wide-spaced aisles. Access to the consultation room was promoted through the team leaving the door open when it was not in use. All equipment within the room was stored securely and no information was left in the room between use. Team members were able to monitor access into the room. The room was clean and professional in appearance. Access into the dispensary was from behind the medicine counter. The team used space in the dispensary well. It used protected space when assembling medicines in multi-compartment compliance packs, and it utilised shelves to hold baskets of medicines waiting to be checked. This practice promoted a safe working environment as work benches remained free of clutter. A partition wall at the back of the dispensary clearly separated a staff break area and staff facilities from the rest of the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from licensed sources. And it stores its medicines safely and securely. The team carry out checks to ensure medicines are safe to supply to people. And it provides relevant information to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy either through an open plan entrance from the health centre or through a door at street level. The pharmacy advertised its opening times. And it displayed some helpful information for people, including details of the recent change in ownership of the pharmacy. But it advertised a travel health clinic both on leaflets and on the nhs.uk website. Team members explained the pharmacy had not provided this service since the change of ownership. Pharmacy team members had good knowledge of the local area. They knew to signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind plastic screens throughout the public area. Team members discussed how they managed requests for these medicines and were vigilant to repeat requests for higher-risk medicines. And they referred these requests to the RP. Several members of the team were observed asking questions and providing counselling when managing a request for a P medicine. The team had some processes to identify higher-risk medicines during the dispensing process. This prompted verbal counselling when medicines were handed out. And the team kept some records of the interventions made by pharmacists on the PMR to support continual care. The pharmacy team was not aware of the full details of recent legal changes about supplying valproate in original packs. Shortly after the inspection, the SI provided assurances of a review taking place to support the pharmacy in fully complying with the legal changes. And they updated the SOP for the supply of valproate to reflect these legal changes. Team members understood the requirements of the valproate Pregnancy Prevention Programme. And confidently discussed how they would dispense prescriptions for a person in the at-risk group.

Team members had access to appropriate information to support them in delivering the pharmacies services. For example, the RP demonstrated their training records and the patient group directions they used when administering vaccinations. 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, and team members used the original prescription when dispensing owed medicines. It kept an audit trail of the medicine deliveries it made to people's homes. And the delivery driver discussed the checks they made when delivering these medicines.

Team members used individual records to support them in supplying medicines in multi-compartment compliance packs. They checked changes to medicine regimens with GP surgery teams and amended the person's compliance pack record to reflect the change. But they did not routinely record details of the checks they made with the surgeries when amending the record to support them in answering any

queries that may arise. The team provided a reminder on week three of each four-week cycle for people ordering their own prescriptions and having their medicines supplied in this way. A sample of compliance packs found clear descriptions and dispensing audit trails on the attached backing sheets. And the pharmacy routinely provided patient information leaflets at the beginning of every four-week cycle of compliance packs.

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 a suitable fridge, equipped with a thermometer. The pharmacy kept temperature records for the fridge. But there were gaps in recording of several days at a time on some recent temperature records. Temperature records either side of the gaps showed the fridge had remained within the required range of two and eight degrees Celsius.

Team members explained they completed regular date checking tasks, but they did not record the checks they made. This made it more difficult for the team to know exactly when the last date check of stock took place. A random check of dispensary stock found one out-of-date split pack of amlodipine tablets. Team members routinely checked expiry dates when dispensing medicines to ensure they remained safe to supply. They 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. It received medicine alerts through email and the SI contacted the team directly to raise any urgent alerts with them. The team demonstrated recent action it had taken to quarantine stock ahead of sending it back to a wholesale, following a medicine recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. And pharmacy team members use the equipment and facilities with care to protect people's confidentiality.

Inspector's evidence

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. It kept equipment for its consultation services locked away when not in use. Some consumables to support the delivery of a diabetes screening services were out of date. Replacement consumables were available within the pharmacy. Team members explained the service had not been accessed for some time, and they provided assurances they would remove or replace the expired consumables. Appropriate equipment to support the emergency treatment of an anaphylactic reaction was available to support the safe provision of the pharmacy's vaccination services.

The pharmacy stored bags of assembled medicines in the dispensary, out of the direct view of the public area. Its computer monitors were suitably protected from unauthorised view. Pharmacy team members used a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone. They had access to written reference resources as well as the internet. And they used NHS smartcards and passwords when accessing people's medication records.

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.