General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Superdrug Pharmacy, 339-341 Wells Road, Knowle, BRISTOL, Avon, BS4 2QB

**Pharmacy reference:** 1028736

**Type of pharmacy:** Community

**Date of inspection:** 07/01/2020

## Pharmacy context

This is a community pharmacy in a shopping centre in the south-eastern suburbs of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines and a variety of other items. The pharmacy supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

## 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 | 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's working practices are generally safe and effective. It keeps the up-to-date records that it must by law. The pharmacy is appropriately insured to protect people if things go wrong. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But, they do not record all mistakes and so are missing the opportunity to learn from these in order to prevent them from happening again.

### Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded but the error rate was relatively high for the volume of prescriptions with an average of two errors each month for the last few months. Incident reports had been completed but no learning points or actions taken to reduce the likelihood of similar recurrences were recorded. In addition, near misses were not being recorded. The pharmacist said that the company's electronic recording system did not encourage recording at the time of the error because the computer was constantly needed for the labelling of prescriptions. She said that she would look into having a paper record that could be uploaded electronically when time allowed. The pharmacist did say that all near misses were discussed at the time.

The dispensing work space was divided into distinct two areas; a walk-in area and an area up a few stairs which was used for the assembly of electronically transferred prescriptions (ETP) and multi-compartment compliance aid prescriptions. The pharmacy had several domiciliary patients who received their medicines in compliance aids and the space available for this was limited. All prescriptions including the compliance aids were checked in the upstairs area. There was a dedicated checking bench but the pharmacist was seen to have to interrupt her checking of compliance aids in order to speak to customers. In addition, several baskets waiting to be checked were also on this bench. Both of these issues increased the risk of errors. Shelves below the checking bench were used for compliance aids waiting to be checked.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, calling back, ETP and those for delivery. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined, except for assembled methadone, had been initialled. The pharmacist said that these were for supervised patients and that, in future, she would ensure that there was a robust audit trail of the dispensing process.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was displayed but it was not dated and no local additions had been made. A NVQ2 trained dispenser said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. A medicine counter assistant said that she would refer any requests that she was unsure of, to the pharmacist. But, none of the staff were aware of the NFA-VPS (non-food animal, veterinarian, pharmacist, suitably qualified person)

status of veterinary medicines. The pharmacist said that she would make sure that the staff received training on this.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, most people were satisfied with the service from the pharmacy but the displayed results did not include any areas for improvement and the staff were not aware of any negative feedback. This meant that they were unable to address any issues. The pharmacist said that she would check the NHS Choices website for the full results of the survey.

Public liability and professional indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 January 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure in place and the staff had completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults were available electronically. The pharmacist said that she would print these off and display them.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy generally has enough staff to manage its workload safely. The team members are encouraged to keep their skills up-to-date and they do this in work time. But sometimes, those in training are not allocated extra time towards their courses. The team are comfortable about providing feedback to their manager to improve services and she acts on this.

### Inspector's evidence

The pharmacy was in a shopping centre in the south-eastern suburbs of the city of Bristol. They mainly dispensed NHS prescriptions but several private prescriptions were dispensed via the company's on-line doctor service. Several domiciliary patients received their medicines in compliance aids.

The current staffing profile was one pharmacist, the manager, one full-time NVQ2 qualified dispenser, one part-time NVQ2 qualified dispenser, one full-time NVQ2 trainee dispenser, four part-time medicine counter assistants (MCA) and one part-time MCA trainee.

The pharmacy was behind with their work schedule for compliance aids. The staff said that this was because a dispenser had been off ill. The company had sent some locum help but, on the day of the inspection, the pharmacist had to check some compliance aids that were needed for that day and the following day. In addition, some needed for the next day, had yet to be assembled and were still waiting for stock. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. This time was usually covered by locum dispensers.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed e-Learning such as recently on Voltarol. They also completed compulsory learning, such as on SOPs. They spent about 30 minutes each month of protected time learning but, the pharmacist reported that it was sometimes difficult to allocate additional time to those members enrolled on accredited courses, such as the NVQ2 dispensing assistant course. The dispensary staff reported that they were supported to learn from near misses even though these were curently not being recorded (see under principle 1). The pharmacist said that all learning was documented on her continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged and acted on. A qualified dispenser had recently raised issues with the procedures for the compliance aids. Because of this, the date that they were due to be collected was now highlighted on the patient's name on the shelf where they were stored. There were monthly staff meetings. All the staff were aware of the company's whistle-blowing policy. The pharmacist reported that she was set overall targets, such as for Medicine Use Reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy generally looks professional. It signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk.

### Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing space was limited considering the number of patients receiving their medicines in compliance aids. However, the dispensing benches were mainly organised although, some baskets, waiting to be checked, were stored on top of one another which increased the risk of errors. The floors were clear. There was a dedicated hatch for substance misuse patients. The premises were clean and well maintained.

The consultation room was spacious, well fitted and well signposted. It contained a computer and a sink. Conversations in the consultation room could not be overheard. The computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Many items for sale were healthcare related but several other items were also sold.

## Principle 4 - Services ✔ Standards met

### Summary findings

Everyone can access the services offered by the pharmacy. The services are generally effectively managed to make sure that they are delivered safely. The pharmacy team members make sure that people have the information that they need to take their medicines properly. The pharmacy gets its medicines from appropriate sources. The medicines are stored safely and generally disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

### Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door. The staff could access an electronic translation application for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients and currently did this for one patient.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme as was a sore throat swab test and delayed periods. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. She had also completed suitable training for the throat swab test and delayed periods.

A few substance misuse patients had their medicines supervised and some others took their medicines home. Any concerns about these patients would be recorded on their electronic prescription medication record (PMR). The telephone numbers of key workers were not available. The pharmacy was open for longer hours than the service provider and the pharmacist said that she would get these. Supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion but the medicines for these patients did not always have a completed audit trail of the dispensing process (see under principle 1). The pharmacist said that she would ensure that the 'dispensed by' and 'checked by' boxes on the labels were completed in future.

A number of domiciliary patients received their medicines in compliance aids. As mentioned in principle 2, the assembly of these was behind schedule at the time of the visit. The number of compliance aids done meant that a dedicated dispenser was required to be assigned to this task every day. There was however no separate checking bench for these. And, on the day of the visit, it was seen that the pharmacist was interrupted with the checking of the compliance aids in order to attend to customers. This increased the risk of errors. Any changes or other issues for these patients, mainly with written confirmation, were kept but there was no concise audit trail of these for easy reference by the pharmacist. The assembled compliance aids were stored tidily.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed, except supervised methadone (see under principle 1) by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as

warfarin and lithium. INR levels were asked about. She also counselled patients prescribed amongst others, confusing directions, antibiotics, new drugs and any changes. CDs and insulin were packed were checked with the patient on hand-out. The staff were aware of the sodium valproate guidance relating to the pregnancy protection program.  They had no patients in the at risk group.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. The pharmacist reported that the patients who used the pharmacy were generally well informed. She said that the pharmacy had several diabetic patients and she gave them healthy lifestyle advice during MURs. In the past she had referred a young patient with raised blood pressure to his doctor.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Specials were obtained from Alliance Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned but a few out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances but no list of such substances that should be treated as hazardous for waste purposes. The pharmacist gave assurance that she would obtain and display the list, and also, train all the staff on its contents.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 16 December 2019 about ranitidine tablets. The pharmacy had none in stock and this was recorded.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is clean and fit-for-purpose.

### Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 – 500ml). There were two tablet-counting triangles. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

## 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. |