General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 38 Fitzroy Street, CAMBRIDGE, Cambridgeshire, CB1 1ER

Pharmacy reference: 1029214

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

The pharmacy is in a large city centre shopping precinct. It provides NHS and private prescription dispensing mainly to local residents. The team also dispense medicines in multi-compartment compliance packs for some people. And they provide treatment and support to drug and alcohol service users. There is a seasonal flu vaccination service.

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

Members of the pharmacy team work to professional standards and identify and manage risks effectively. They are clear about their roles and responsibilities. They generally log mistakes they make during the pharmacy processes. And they learn from these to avoid problems being repeated. The pharmacy keeps its records up to date and these show that it is providing safe services. It manages and protects information well and it tells people how their private information will be used. The team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures which covered the services provided. The staff said that they had read them and followed them and there was evidence of this. Some near misses were recorded on a computer programme which fed back to head office and allowed analysis of the types of mistakes made. The pharmacist said that they did not always record near misses as accessing the computer was not always convenient, and then they got forgotten. Look alike, sound alike medicines had been identified as an issue and amlodipine and amiloride had been separated in the dispensing drawers to try to prevent picking errors. The pharmacist was new in post (seven weeks) and said that he had been identifying changes the team needed to make in the way the team worked. He had implemented some changes but knew there was some more that he wanted to do. He was undertaking the appropriate training in preparation for providing more services, once he was more confident in his role as pharmacist manager.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice.

The pharmacy sought the views of people on the service provided by the pharmacy in an annual survey. The recent report had showed that the users of the pharmacy were a wide range of ages, and that they were generally satisfied with the services provided. The pharmacy had professional indemnity and public liability insurances in place.

The pharmacy team recorded private prescriptions and emergency supplies in a book. These records were up to date. The controlled drugs registers were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. A random check showed that the records for a specific item were correct. Fridge temperatures were recorded daily and were within the recommended range.

The pharmacy team members were observed to only use their own NHS smartcards to access electronic prescriptions and summary care records. The PIN numbers for these were kept securely. Confidential information was kept in the dispensary and consultation room, where it could not be accessed by unauthorised people. The computers were password protected and the screens could not be viewed from the counters. Confidential waste was separated and then disposed of using a licensed waste contractor. There was a notice about how people’s information would be used.

The pharmacist had undertaken the required level of safeguarding training to provide flu vaccinations. There were local contact telephone numbers for the safeguarding teams in the area on the wall of the

dispensary. Staff reported that they had a number of vulnerable people who used the pharmacy and that referrals were sometimes made to the night shelters and surgeries regarding these people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe services. Training is provided by the company and staff find this useful to help keep their skills and knowledge up to date. The small team work well together.

Inspector's evidence

The team consisted of three staff; the full-time pharmacist and two part-time dispensers who had both completed level 2 dispensing training. Locum pharmacists were used to cover the pharmacist's days off. The pharmacist had been in post seven weeks. The pharmacist reported that the targets set by head office did not affect his professional judgements.

The company provided regular training for their staff using an e-Learning platform. The staff were up to date with the training packages and reported that they found them useful. Training had included the General Data Protection Regulation (GDPR) and safeguarding, as well as professional subjects.

It was observed that the team worked well together, and the dispensers said that they felt able to make suggestions to the pharmacist about how things could be changed to improve people's experience using the pharmacy. They had made suggestions about how to make it easier to scan medicines to comply with the Falsified Medicines Directive (FMD). All staff had regular appraisals.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean and provide a safe, secure and professional environment for people to receive healthcare. But it could do more to make sure some areas are kept clean and tidy.

Inspector's evidence

The dispensary and counter areas were clean tidy and bright. The dispensary was of adequate size for the volume of prescriptions dispensed. Separate areas of bench were used for dispensing and accuracy checking.

The consultation room provided a confidential area to provide services, although it was quite small and may not be large enough if someone fainted following a vaccination. There was a hatch in the wall to allow counter staff to observe what was happening in the room. There was a chaperone policy notice on the door. The consultation room had balls of dust on the floor and the sink was covered in limescale. It was a little untidy too. When this was pointed out to the pharmacist he said that it would be cleaned as soon as the inspection was over. And he would ensure that it presented a professional image to people being vaccinated, as an ongoing task.

There was another private area which was used for supervised consumption. This was to one end of the counter and was well-screened.

The staff had access to toilet facilities. There was hot and cold water available in the dispensary sink. The pharmacy was open for fewer hours than the rest of the shop. The registered premises were locked to prevent public access when the pharmacist was not present, and the pharmacy closed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's working practices are safe and effective and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people about where they can get other support. They take actions themselves to improve accessibility for people. Drug and alcohol service users are offered supervised consumption and a needle exchange service in a caring manner. The protection of people taking high-risk medicines could be improved.

Inspector's evidence

Access to the pharmacy was via the main shop and was level from the pavement in the precinct. Services were advertised in the windows of the shop and around the pharmacy area. There were facilities for providing supervised doses in privacy. One person was supplied medicines with dosage labels in large print, as her eyesight was poor.

The pharmacy used a dispensing audit trail to identify who had dispensed and checked each item. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Prescriptions where the person was waiting were put into red baskets to highlight this fact.

Some people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way when supplied to people. But these labels were not attached to the packs, meaning they could easily be separated, and the information lost. The packs also had tablet descriptions to identify the individual medicines. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs. When dispensed packs were left sealed but unlabelled until the pharmacist checked them. This increased the risk of errors.

The people taking supervised instalment doses were offered use of a private area. These doses were pre-prepared, using hand written labels with the person's name, the quantity and 'sugar' or 'SF'. They were then re-labelled using the electronic patient medication record (PMR) when the person came to collect their dose. This process ensured that the PMR accurately reflected what had been supplied but could introduce other risks. For example, giving the incorrect quantity. There was a needle exchange service, and the pharmacist reported that they supplied around 400 packs a month. They did not get as many returned packs, but the local hostel and night shelter insisted that any 'works' were handed in before a person could stay there, and so often the people wanting packs did not have any to exchange. It was observed that the whole team had a very positive attitude to providing this service.

People taking warfarin, lithium or methotrexate, who brought their own prescriptions into the pharmacy or had their prescription on repeat, were not always asked about any recent blood tests or their current dose. If the staff noticed these items on a prescription when handing it out they would ask the person. So, the pharmacy could not show that it was monitoring these people in accordance with good practice. People who were receiving prescriptions for valproate in the at-risk group were not routinely counselled regarding pregnancy prevention where needed. One person in this group had her sodium valproate in multi-compartment compliance packs which were not marked. There were

educational materials including stickers and cards available, but they were not being used.

People using the flu vaccination service were making appointments, as it was the start of the season. There was a lot of interest in the service, but the staff were waiting for the main stock of vaccines to arrive. There were patient group directives in place for flu vaccinations, for both the NHS and private services.

The pharmacy got its medicines from licensed wholesalers and stored them in dispensary drawers and on shelves in a tidy way. There were ‘use first’ stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. The pharmacy was scanning medicines in compliance with the FMD although the pharmacist was not sure that the information was being sent back to the MHRA. Patient-returned controlled drugs were listed in a book and destroyed as soon as possible after receipt.

Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for use with a specific liquid controlled drug, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment had been safety tested and had passed.

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.