General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 87-93 High Street, SHEERNESS, Kent, ME12 1TX

Pharmacy reference: 1032937

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre and it is surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, minor ailments (Community Pharmacy Consultation Service) and the influenza vaccination. It supplies medication in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And also supplies these packs to a small care home with fewer than ten residents. It provides substance misuse medications to a small number of people.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.1	Standard not met	The pharmacy does not properly maintain the drawers in the dispensary to ensure that these do not pose a health and safety risk to team members.
		3.4	Standard not met	The registered premises are not properly secured from unauthorised access when the pharmacy is closed.
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 adequately identifies and manages most of the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and regularly seeks feedback from people who use the pharmacy. It generally keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood. They completed tests to check their understanding. The pharmacist said that she checked that all team members had read any updated SOPs.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where a medication had been added to a multi-compartment compliance pack when the medication had been stopped by the hospital. The pharmacist said that there was better written communication between team members now to ensure that important information was passed on.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would not open if the responsible pharmacist (RP) had not turned up. She confirmed that she would not carry out any dispensing tasks before the pharmacist had arrived. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not present in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And there were signed in-date Patient Group Directions available for the relevant services offered. The private prescription record and emergency supply record were completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked regularly. Liquid overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. There were two occasions in May 2019 where the locum pharmacists had not completed the RP log on the days that they were working. The

pharmacist said that she would contact the pharmacists who were working on those days and complete the log.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the recent survey were displayed in the shop area and were available on the NHS website. Results were positive with 100% of respondents satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that she was not aware of any complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. The team discusses adverse incidents and uses these to learn and improve. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. The team members can raise any concerns and they can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and one trained dispenser working during the inspection. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person. The pharmacist said that there were a few people who was regularly requesting to purchase painkillers and she had referred them to their GP.

The dispenser had completed an accredited dispenser course. She completed regular online modules and these were checked by the pharmacist. She had completed some training recently about Syndol, and modern slavery. And she confirmed that she could complete the training in the pharmacy during quieter periods or at home. The pharmacist said that the apprentice (who was not working on the day of the inspection) was allowed two hours of study time each week (one hour at home and one hour in the consultation room). The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. She confirmed that the pharmacy had recently received the SOP for the minor ailments service and she was due to complete the associated training before the service was implemented. The pharmacist said that the regular locum had completed the training and could provide the service.

The dispenser said that she felt comfortable about discussing any issues with the pharmacist. The pharmacy received a weekly newsletter from the pharmacy's head office which included important information. The monthly newsletter included learnings from dispensing incidents and near misses throughout the organisation. The pharmacist ensured that team members had read and understood the information and these were kept for future reference.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that she did not feel under pressure to achieve the targets and she would not let them affect her professional judgement or decision-making.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises provide a clean environment for the pharmacy's services. But the pharmacy does not ensure that the registered premises are properly secured when the pharmacy is closed. And the damaged drawers in the dispensary pose a health and safety risk to team members.

Inspector's evidence

Air-conditioning was available; the room temperature was suitable for storing medicines. Pharmacy-only medicines were kept behind the counter. There was a restricted view of the medicines counter from the dispensary. The dispenser said that there used to be a bell at the counter for people to alert the team, but this had been removed a few years ago. The pharmacist said that she frequently had to check to see if there was anyone waiting to be served. The pharmacy had shutters, but the pharmacy premises could not be properly secured from unauthorised access when the pharmacy was closed. There was a 38cm gap for team members to access the pharmacy at the side of the counter. Team members struggled to enter and leave the pharmacy via the side of the counter. The narrow gap was caused by a post which the shutters closed into.

There were several broken or missing drawers in the dispensary. One had a broken corner which was sharp and could potentially harm a member of the team. Some of the drawers did not stop when opened and the dispenser said that one had fallen onto the floor when it was opened fully. This meant that there was a risk that a team member could be hurt if this happened again. The pharmacist said that she had reported the drawers, shutters and size of the consultation room previously. She said that contractors had taken photos and measurements of the drawers several times, but these had never been replaced or fixed.

There were one chair in the shop area. The pharmacist said that people tended not to wait at the pharmacy for their prescriptions to be dispensed and instead came back later. The pharmacy's consultation room was small and wheelchair users would struggle to access the room comfortably. The pharmacist said that she had to stand up if a wheelchair user was in the room. The room was located in the shop area. And it was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. There was an induction hearing loop which appeared to be in good working order, but team members were unsure if this was the case as they had not yet used it.

The pharmacist said that the pharmacy did not supply many higher-risk medicines to people. She said that she would check monitoring record books for these people. And confirmed that she checked that people taking methotrexate were taking folic acid on a different day. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. The pharmacist said they checked CDs and fridge items with people when handing them out. She confirmed that the pharmacy supplied valproate medicines to a few people in the at-risk group, but those people did not need to be on the Pregnancy Prevention Programme. She said that she had discussed the risks with them. The pharmacy had the up-to-date patient information leaflets or warning cards available. The pharmacist said that she supplied these to people when needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. There were a couple of boxes containing mixed batches found with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The pharmacist said that she would remind team members to keep medicines in their original packaging.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. The pharmacist said that people were contacted to remind them that they had medicines waiting collection. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that most of the people who received their medicines in multi-compartment compliance packs had been referred from their GP. The pharmacy had assessment forms available to help the pharmacy assess if the packs would be suitable for people. The pharmacy did not generally order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs. The pharmacist said that the pharmacy ordered prescriptions for a few vulnerable people and this had been discussed with their GP. The pharmacy kept a record for each person which included any changes to their medication. There were no completed packs available to inspect. The pharmacist

explained how the packs were assembled and what information was included on the backing sheets.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, the MHRA and the pharmacy's head office. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that team members had undertaken training on how the system worked. She said that most of the medicines were not recognised when scanned so they did not routinely scan items.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for methotrexate/cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around one year. The weighing scales were in good working order. The phone in the dispensary was not portable, but low-level conversations could not be heard from the shop area.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. A data logger was used so that the pharmacy could check how long the medicines had been out of the range. This information was downloaded and checked each month in addition to the daily checks. The fridge was suitable for storing medicines and was not overstocked. The pharmacist said that a new fridge had been received a few days after the previous one had broken. She had discovered that the temperature of the previous fridge had reached minus 6 degrees Celsius. She had informed the pharmacy's head office immediately and all of the medicines inside had been disposed of. The old fridge was waiting to be removed from the pharmacy and was taking up floor space in the small dispensary.

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.