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: 12/03/2020

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 75% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, blood pressure checks and the influenza vaccination. It supplies medicines as part of the Community Pharmacy Consultation Service. And 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 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	1.2	Good practice	The pharmacy 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. And learnings are shared throughout the company.
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 identifies and manages 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 protects people's personal information and it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy identified and managed the risks associated with pharmacy activities. There were documented, up-to-date standard operating procedures (SOPs), and 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. 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 the wrong medicine had been supplied to a person. The pharmacist said that she realised the error when she was making the entry in the register. She contacted the prescriber to inform them and asked them to inform the person. The pharmacy completed a monthly patient safety report following the reviews of the near misses and dispensing incidents. The outcomes from the reviews were discussed openly and learning points were also shared with other pharmacies in the group.

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 pharmacist had not turned up. And she said that team members would not be able to access the pharmacy. She explained that she would not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The correct responsible pharmacist (RP) notice was clearly displayed and the RP log was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. 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. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription record was completed correctly. Records of emergency supplies were not consistently made in the same place; this could make it harder for the pharmacy to review the records if there was a query. The computer was used to record emergency supplies of prescription-only medicines and some had also been recorded in a book. The nature of the emergency was not always recorded on the computer and some records of emergency supplies were not in the book. The pharmacist said that she would remind team members to complete the emergency supply record correctly in the future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used her own smartcard during the inspection to access the NHS spine. The dispenser said that her smartcard was currently locked and the regular pharmacist was in the process of requesting for it to be unlocked. She said that her smartcard was secured in the pharmacy. 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 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results were positive and 100% of respondents were 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 dispenser said that she was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) 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 dispenser said that she was not aware of 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 team members to provide its services safely. The team discusses adverse incidents and uses these to learn and improve. They 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. Team members are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. But the pharmacy does not always ensure that team members are enrolled on approved pharmacy courses within the required time frame.

Inspector's evidence

There was one regular locum pharmacist and one trained dispenser working during the inspection. The delivery driver was briefly in the pharmacy at the start of the inspection. She said that she occasionally worked on the medicines counter, but she had not completed an accredited course for that role. The pharmacist said that she would check with the pharmacy's head office to ensure that the driver was enrolled on a suitable course. Following the inspection, the inspector received confirmation from the pharmacy manager and the superintendent pharmacist that they were in the in the process of enrolling the driver onto an accredited course. 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. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

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 dispenser had completed an accredited dispenser course. She completed regular online modules and these were checked by the pharmacist. She said that she had recently completed some training about a new medicine used for preventing malaria. She confirmed that she could complete the training in the pharmacy during quieter periods or at home. The dispenser said that the apprentice (who was not working on the day of the inspection) had passed all the relevant modules and was now a qualified dispenser. he driver said that she had completed some online modules provided by the pharmacy's head office. The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. She said that she had had recently completed some training about 'look alike and sound alike' medicines and sepsis, which were provided by the CPPE.

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 company. The dispenser said that team members read 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 felt under a certain amount of pressure to achieve the targets, but she would not let them affect

her professional judgement or decision-making. She said that she felt able to take professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned away from the medicines counter to help minimise the chance of conversations at the counter being heard. The 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 and these were clean.

Principle 4 - Services ✔ Standards met

Summary findings

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. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

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.

The pharmacist said that the pharmacy did not supply many people with higher-risk medicines such as methotrexate or warfarin. Prescriptions for higher-risk medicines were not routinely highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. 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 CDs and fridge items were checked with people when these were handed out. She confirmed that the pharmacy supplied valproate medicines to a few people in the at-risk group. And any people who needed to be on the Pregnancy Prevention Programme had been spoken with. The pharmacy did not have the up-to-date patient information leaflets or warning cards available. The dispenser said that she would request these from the manufacturer.

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 and lists were kept so that these items could be removed from dispensing stock before they were out of date. The dispenser said that short-dated items were sometimes transferred to other pharmacies within company if they could be used. There were no expired items found with dispensing stock and medicines were kept 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 dispenser said that the pharmacy did not usually order prescriptions on behalf of people who received their medicines in these packs. She explained 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 dispenser explained how the packs were assembled and what information was included on the backing sheets. She said that patient information leaflets were routinely supplied to people.

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 and it was being used. The pharmacist said that team members had undertaken training on how the system worked. And there were written procedures available.

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 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 if there was a problem. 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.

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.