General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 78-80 High Street, SITTINGBOURNE, Kent, ME10 4AJ

Pharmacy reference: 1032965

Type of pharmacy: Community

Date of inspection: 15/07/2022

Pharmacy context

The pharmacy is located on a busy high street in a town centre which is in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including dispensing NHS prescriptions and the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a few people.

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

The pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. But the pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. There were documented, up-to-date standard operating procedures (SOPs) available. And team members had signed to show that they had read, understood and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. The trainee dispenser said that she identified and rectified her own mistakes which were noticed by the pharmacist. But near misses were not routinely recorded by team members. Recording and reviewing near misses might help the pharmacy identify areas for improvement. Medicines in similar packaging or with similar names were separated where possible. The pharmacist explained how she would deal with a dispensing error, where a dispensing mistake had reached a person. She would undertake a root cause analysis, complete an incident report form and inform the pharmacy's head office. Team members were not aware of any recent dispensing errors.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And 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 trainee dispenser said that team members did not have access to the dispensary area if the pharmacy had not turned up in the morning. She knew that she should not sell pharmacy-only medicines if the pharmacist was not in the pharmacy. But she thought that she was allowed to hand out bagged items. The inspector reminded her what she could and could not do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. And the private prescription records were completed correctly. Controlled drug (CD) registers examined were largely 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 CD item checked at random was the same as the physical amount of stock available. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The right responsible pharmacist (RP) notice was not displayed at the start of the inspection This was changed to show the details of the RP who was working during the inspection. The RP record was largely completed

correctly, but there were alterations made with no indication as to who had made the amendments.

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 to access the NHS electronic services. The trainee dispenser said that she had spoken with the pharmacy manager about ordering her a smartcard, but she was not sure if this had been actioned yet. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members had done some training about protecting people's information.

The pharmacy had not carried out a patient satisfaction survey for 2020 to 2021 due to the pandemic. The trainee dispenser said that the pharmacy was in the process of carrying out a survey using the Community Pharmacy Patient Questionnaires. The complaints procedure was available for team members to follow if needed and details about how people could make a complaint were available on the pharmacy's website. The trainee dispenser was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She was not aware of any recent 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. They do the right training for their roles. And they can do some training in work time. Team members are able to raise concerns to do with the pharmacy or other issues affecting people's safety. And they have regular meetings. This means that they can help improve the systems in the pharmacy. The team members 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 locum pharmacist and one trainee dispenser working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. Most team members who worked at the pharmacy had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role.

The trainee appeared confident when speaking with people. She asked people relevant questions and referred to the pharmacist when needed, passing on the information she had been given. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And 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.

The pharmacist felt able to make professional decisions and she was aware of the continuing professional development requirement for the professional revalidation process. She explained that she had recent undertaken some learning about skin health, minerals, and vitamins. The trainee dispenser said that she mostly completed her training modules at home, but she could do it at the pharmacy during quieter periods. And this had meant that the regular pharmacist had been available to help her.

The trainee dispenser felt comfortable about discussing any issues with the pharmacist or making any suggestions. And she had ongoing informal appraisals. There were regular store meetings to allow team members to discuss any issues.

Targets were set for the New Medicine Service but team members working during the inspection were not sure if the pharmacy usually hit the targets. The pharmacist said that she would not let targets affect her professional judgement and she provided services for the benefit of people who used the pharmacy.

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 and this presented a professional image. Pharmacy-only medicines were kept behind the counter, but some were not always kept secure when the pharmacy was closed. The pharmacist said that she would ensure that these were kept secure in future. 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 and the room temperature was suitable for storing medicines.

The consultation room was accessible to wheelchair users and it was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. There was a hatch from the consultation room to the dispensary. The pharmacist said that this was sometimes used. 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

The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It dispenses medicines into multi-compartment compliance packs safely. And 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. Shop team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The trainee dispenser said that the doors remained open most of the time to allow access to the premises. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that she checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant warning sticker, warning cards and patient information leaflets available. The trainee dispenser said that the pharmacy's computer highlighted higher-risk medicines such as methotrexate and warfarin. But prescriptions for these medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And a record of blood test results was not kept. So this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 CDs were highlighted, but prescriptions for Schedule 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. These points were discussed with the team during the inspection.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly and this activity was recorded. Items due to expire within the next six months were marked. Lists were kept for items with a short expiry date and these items were removed around one month before they were due to expire. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked frequently. '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 regularly and people were contacted to remind them that they had items waiting collection. Any items remaining uncollected after around one month were returned to dispensing stock where possible. The 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 people had assessments carried out by their GP to show that they needed

their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacist said that the pharmacy contacted people to see if they needed their 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The trainee dispenser said that she would ensure that these were attached in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

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, and two signatures were recorded.

Deliveries were made by a team member. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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. If a courier was used to deliver medicines on behalf of the pharmacy, the courier would sign to show that they had taken the medicines to be delivered.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. An alert had been received the day before the inspection and it was not clear as to whether it had been actioned. Team members were not sure where the pharmacy might record any action that might have been taken. The affected medicines were already being stored correctly. The trainee dispenser said that she would check with the regular pharmacist about the action taken in response to alerts and recalls.

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 used to measure marked for use with certain liquids only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked twice a day. Maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. 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.