General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 3;5;7 Stonybutts, Blackburn Shopping Centre, BLACKBURN, Lancashire, BB1 7JD

Pharmacy reference: 1033117

Type of pharmacy: Community

Date of inspection: 25/11/2019

Pharmacy context

The pharmacy is in a Superdrug store in a shopping mall in the centre of Blackburn. It mainly dispenses NHS prescriptions. And some private prescriptions, including a number from its on-line doctor service. The pharmacy supplies medicines for people in multi-compartment compliance packs. And it delivers medicines to people's homes. It provides a range of NHS and private services, including seasonal flu vaccinations.

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 identifies and manages the risks with the services it provides. The team members follow up-to-date written procedures. And they are good at completing regular checks on key governance tasks. The team members have training and guidance, so they understand how to protect the safety of children and vulnerable adults. They keep people's private information secure. The team members respond appropriately to mistakes they make during dispensing. And they make changes in the pharmacy to prevent similar mistakes happening again. People can raise concerns and provide feedback about the pharmacy's services. And the team knows what to do to resolve any concerns. The pharmacy keeps most of the records it must by law.

Inspector's evidence

The pharmacy was situated to the rear of a Superdrug store. The dispensary was set to the side of the pharmacy counter. And although the pharmacy team couldn't see the customers from the dispensary the pharmacist's checking bench allowed him to oversee sales and advice the team gave to people at the counter.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) that were relevant for the services provided. For example, it had SOPs for controlled drug (CD) management, dispensing processes, services and the responsible pharmacist (RP) regulations. The pharmacy held its SOPs electronically, but the team also had printed paper copies to refer to. The SOPs clearly stated the version number, date of issue and the review date. They had been authorised by the superintendent. The SOP training records were held electronically. And the team's training records for SOP completion, including for the driver were up to date. The pharmacy team members were observed during the inspection following procedures in the SOPs. For example, by consistently asking people to confirm their name and address prior to handing out their medicines. And on viewing the completed driver delivery sheets, the driver obtained people's signatures on the reverse of the form to protect people's confidentiality.

The pharmacy held electronic near miss error records electronically on Pharmapod. During the inspection there was a near miss error when a dispenser had selected the incorrect size of diabetic needles. The pharmacist and the two team members working discussed this error at the time. And the dispenser made an electronic record directly on to the electronic system. The pharmacist and dispenser further discussed why the error could have happened, what consequences it could have on the person and what she could do differently in the future to prevent a similar mistake. The team members openly discussed some other near miss errors that had happened. And the reasons why they thought they could have occurred. It was felt that some mistakes happened when there were different formulations and strengths available, but only one was dispensed regularly. For example, bendroflumethiazide 2.5mg and 5mg tablets. The pharmacist described how he had separated some of these products into separate drawers. The team had monthly patient safety discussions using the information gathered from the near miss errors entered into the electronic system. A copy of the October 2019 report was seen. The team hadn't added any additions to the printed sheet of any further learning following the monthly discussions. And there wasn't an indication of which team members had been at the meeting. The pharmacy also reported any dispensing incidents electronically. And evidence of previous reports was seen. The pharmacist and pre-registration pharmacist had recently completed training from the Centre

for Pharmacy Postgraduate Education (CPPE) on look-alike and sound-alike (LASA) medicines. And they had found it useful. The pharmacists had separated several LASA medicines into different drawers. But had not used any other way to highlight these medicines during dispensing.

The team members used a pharmacy audit book to ensure key governance tasks were completed regularly. They logged daily fridge temperatures in this book, together with CD key log entries. The RP and the Superdrug store manager signed the CD key log to ensure there was a robust audit trail. Team members, as part of their roles, completed weekly and monthly tasks as directed in the pharmacy audit book. These included weekly date checking and CD balance checks. The pharmacy had an up-to-date business continuity plan, from March 2019. The pharmacist manager was named as the business continuity lead. The pharmacist displayed the correct RP notice. The pharmacy team members understood their roles and responsibilities. These were documented in the SOPs. The dispenser was clear what activities could and couldn't be completed when the RP wasn't signed in.

The pharmacy had an up-to-date complaints policy, dated June 2019. And it was available for the team to refer to. The pharmacy advertised to people how to complain and give feedback in its practice leaflet. People could pick these leaflets up from the pharmacy counter area. The pharmacist described how the team escalated complaints to him to resolve. And how on one occasion he had discussed two connected complaints with his area manager, who had resolved the matter. The pharmacy used an annual customer survey to ask for people's views. And it advertised the results in the pharmacy and on nhs.co.uk. But the results had been displayed above the Pharmacy (P) Medicines, and behind the counter. People wouldn't be able to read the suggested improvements from the retail area. The pharmacist explained that he had suggested to have an area closer to the pharmacy counter, so people could see it and the other notices stored there more easily. But this idea hadn't been taken forward.

The pharmacy had up-to-date professional indemnity insurance. It kept an RP record. Of the sample checked all entries were correct. The pharmacy kept complete records of private prescription supplies. Up until the end of October these had been hand written, but the pharmacy now kept the records electronically. Both met the requirements. The pharmacy now kept its records of emergency supplies electronically. But there was no detail of the reason for the emergency supply. The pharmacist completed a test entry and realised that this information needed to be entered on to the notes section on a different tab on the system. So, future entries would comply with requirements. The team completed the certificates of conformity for unlicensed specials supplies in line with Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

The pharmacy kept complete entries for CDs in a paper CD register. The team members checked the stock balance against the register entry on a weekly basis. A sample looked at showed the entries met legal requirements with completed headers and no entries altered. There was evidence that any discrepancies in the balances had been investigated and corrected. Two register balances were checked for Shortec 5mg capsules and Durogesic 12microgram patches. And these matched the actual stock quantity. The pharmacy kept a record of CDs returned by people to the pharmacy. The pharmacist described how any returns were destroyed regularly. And that he checked this was completed as part of the pharmacy audit checklist. Some had been destroyed in October 2019, and the destruction had been witnessed.

The pharmacy had a data privacy policy, dated June 2019. And an information governance (IG) policy document, dated March 2019. It displayed a notice to customers about handling confidential information. But it kept this above the Pharmacy (P) Medicines, behind the counter. People wouldn't be able to read the notice from this area. The pharmacy's practice leaflet detailed information about the private information the pharmacy kept on people. And that it complied with the data protection (DP)

act and the NHS code on confidentiality. There was no mention of the General Data Protection Regulation (GDPR). And the team members could not be sure when they completed GDPR training. The pharmacy team members used a basket, clearly labelled for shredding to collect any confidential waste from the dispensing process. And they shredded this information several times during the inspection using a cross shredder. The pharmacist explained that due to the size of the premises it was important the confidential waste didn't build up. The pharmacy used confidential waste sacks for larger amounts of waste. And these were removed from the premises for destruction. The team members were aware of the importance of keeping people's information secure.

The pharmacy had a safeguarding policy, dated Jan 2019, for the team to refer to. And it had local NHS Blackburn and Darwen guidance to refer to. And the local safeguarding team contact details. The pharmacist and pre-registration pharmacist had both completed safeguarding training level two, with CPPE in 2019. The pharmacy team had completed level one safeguarding training. And they had completed dementia friends training. The pharmacist had previous experience of escalating a safeguarding concern. And more recently he had been worried about a person who regularly used the pharmacy. And he had spoken to the prescriber about his concerns, so the person received extra support. The pharmacy had a chaperone policy in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and skilled people to provide the pharmacy's services. And it plans well for holidays and absences. The team members complete regular training relevant to their roles and the services provided. And they discuss their performance and any learning needs both informally and during performance appraisals. They work well together and are comfortable suggesting ideas to improve their ways of working.

Inspector's evidence

On the day of the inspection the RP was the pharmacist manager. A part-time dispenser and a pre-registration pharmacist supported the RP. The pharmacy also employed another part-time dispenser and a part-time driver. A regular relief pharmacist and regular locums covered when the pharmacist manager was not working. He worked four days a week. Generally, one dispenser worked in the morning and the other in the afternoon. The pharmacist worked an hour in the morning and an hour at night with only the pre-registration pharmacist. On a Saturday the pharmacy usually only had dispensing cover in the morning. This was because the pharmacy was very quiet in the afternoon. But if the pharmacy booked a locum who had not worked in the pharmacy before the pharmacist manager arranged for a dispenser to work all day Saturday. The pharmacist described the importance of taking a mental break between dispensing and self-checking during this time. The team members were seen discussing and managing the workload. And appropriately offering people advice and resolving queries. They asked relevant questions when recommending over-the-counter medicines. And they appropriately referred queries to the pharmacist. For example, when there was a request for a laxative preparation. The pharmacist was seen providing support and advice to people at the pharmacy counter and in the consultation room throughout the inspection. The pharmacist manager organised the staff rotas in advance. And displayed up-to-date rotas in the dispensary for the team members to see. They covered absence and holidays between themselves. And the manager could escalate any request for cover to the area manager. But he had not needed to.

The pre-registration pharmacist had started their role in August. And she felt supported in her training. She discussed her progress with her manager informally whilst working and during regular weekly 1-2-1 meetings. She was due to attend residential training with other pre-registration pharmacists throughout the year. She had completed training relevant to her role such as safeguarding and LASA medicines training. She had completed some training regarding smoking cessation and the cycle of change. And she had presented her learning to the other team members, so they could benefit from this learning. The pharmacist completed training relevant to the services provided, including flu vaccination training. All team members completed regular mandatory monthly online training modules. The manager demonstrated that the team had completed modules such as the SOPs, dementia friends training and product knowledge training on Voltarol. The team members completed some of the training when the pharmacy was quiet. But they did not have regular protected training time. And they completed training at home sometimes. The pharmacy provided additional voluntary modules for team members to complete relating to subjects that they were interested in. Or if they had a learning need. The pharmacy held documented annual performance development reviews (PDRs). So, the team member could discuss what had gone well and what they could improve on. And to identify any training needs. The pharmacy team held monthly meetings to discuss near miss errors and any other patient safety information. The team members were comfortable discussing their mistakes during the

inspection. And keen to learn from them. The pre-registration pharmacist suggested an improvement in the dispensing process to identify medicines with different formulations that could result in a selection error. She felt if this was noticed when selecting the product during labelling, then the form or strength could be highlighted on the prescription. This would help to prevent mistakes in selection. The team listened to her suggestion. The pharmacy had a whistleblowing policy. And it was displayed on the notice board. But the dispenser was unsure about what this meant and when she would use it. She was comfortable raising concerns with the team and the manager. The pharmacy set targets for a variety of services. And performance was tracked, so the team members knew how they were performing against target. But the pharmacist was not under pressure to meet these targets. The pharmacist liked providing services, so he could help people. And he used his professional judgement when providing services for people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is small but of a suitable size for the services provided. And the team manages the workflow well to keep the pharmacy tidy. The pharmacy is secure. And it has a consultation room where people can talk privately.

Inspector's evidence

The pharmacy was small in size and suitably clean. The team kept the benches and floor free from clutter. The team had an organised workflow. And there was enough bench space for the services provided. The pharmacy team reported maintenance issues to the company head office. The team members had found one of the seats they used in the waiting area broken. They had removed it from the public area and reported it. This left just one seat for people to sit on when waiting for prescriptions and services. The pharmacy had a consultation room, which it kept locked. It was small, but people could sit down with the pharmacist to speak privately. The pharmacist used the room several times during the inspection. And conversations couldn’t be heard outside.

The pharmacy had staff toilets and facilities shared with the Superdrug store. There was hot and cold running water in the dispensary. It had two sink basins, so medicines preparation could be segregated. The pharmacy’s heating and lighting were sufficient. And it had air conditioning it used during periods of hot weather.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It advertises its services appropriately. And it manages and delivers them safely and effectively. The pharmacy team members check that people taking higher risk medicines have the required regular blood tests. And they provide them with relevant advice and written information to help them take their medicines safely. The pharmacy keeps a full audit trail when it delivers medicines to people at home. So, the team can resolve any queries effectively. The pharmacy sources medicines from licenced suppliers. And it stores and manages its medicines well.

Inspector's evidence

The pharmacy's services were displayed in the window. And it had a practice leaflet on display near the pharmacy counter, which detailed some of the services the pharmacy provided. And its opening hours. The pharmacy area was easily seen from the main entrance due to large signage above the pharmacy counter. There was level access to the store and the pharmacy from the shopping mall. And plenty of room around the pharmacy counter for prams and people using wheelchairs. It would be difficult for people in wheelchairs to access services in the consultation room, due to its size. The pharmacy could print large print labels to help people, if needed. It had a hearing loop. But it was not installed and was stored in a box. The pharmacist thought that after the refit it had not been reinstalled. And said he would report it. There was no signage advertising a hearing loop. The pharmacy had a small area at the counter set aside for health promotion. And a range of leaflets for people to pick up. There were some posters displayed in the consultation room for local healthcare services. The pharmacy team couldn't see people waiting at the pharmacy counter from the dispensary. The pharmacy had placed two bells on the counter and a sign directing people to ring for attention. People used the bell some of the time, but on occasions during the inspection staff from the store indicated to people to ring the bell for attention. So, people wishing to access pharmacy services may be missed. The team members also used the bell to alert other team members in the dispensary when they were busy on the counter and needed help.

The pharmacy made good use of stickers during the dispensing process. It had stickers on medication bags awaiting collection for warfarin, fridge lines and for the flu vaccination service. The pharmacy used clear bags for fridge lines and CDs. The team members consistently used baskets during dispensing to reduce the risk of errors. And used different coloured baskets to indicate waiting prescriptions, deliveries and people calling back. They used large baskets for the dispensing of multi-compartment compliance packs. The pharmacy had different areas for labelling, dispensing, prescriptions awaiting checking and a pharmacist checking area. The team had an organised workflow. The team used owing slips for people when not all stock was available. The pharmacy team signed dispensed by and checked by boxes on the dispensing labels to indicate who had been involved in the dispensing process. The pharmacy had a SOP relating to the supply of high-risk medicines. The team had a robust process for dispensing warfarin to people. The pharmacist requested the details of the person's latest blood test before supply. And recorded the result on the person's medication record (PMR). This ensured the warfarin was appropriate to supply. The pharmacy team had conducted an audit relating to people who were taking sodium valproate. The pharmacy team members knew the importance of counselling people taking valproate and the risks of pregnancy. The pharmacy kept a stock of cards and guides in the dispensary drawer where the stock was kept. They didn't have anyone fitting the alert criteria at

present.

The pharmacy supplied medicines in multi-compartment compliance packs to help around 12 people take their medicines. The pharmacy team spread the work over four weeks. And documented when each person's medication was due to be prepared. This was displayed on the dispensary wall. The surgery had a patient-led prescription ordering process. So, people had to order their own prescriptions. A team member telephoned the person to remind them to order their prescriptions when they were due. And chased up if their prescriptions were not received. The team members did this about one week in advance. So, there was time to resolve queries and dispense the medicines into the pack. They checked any differences in a person's medication with the surgery. They kept all details on the person's PMR. This detailed information on the times of administration. And the descriptions of the medicines in the pack. The team member printed cassette sheets and any medication administration record (MAR) charts required. They used rollers to assemble the packs. And they supplied patient information leaflets with the packs each month. The team member generally dispensed the packs in the afternoon when the dispensing workload was reduced, to ensure they made good use of the available bench space.

The pharmacy delivered medicines to people's homes. The delivery driver had read the SOPs appropriate for her role. And this was confirmed from her electronic training record. The driver used a delivery sheet with printed name and address labels attached. It had people's names and addresses printed out consecutively on one sheet. But in line with the pharmacy's SOP people were asked to sign on the reverse of the sheet. This maintained their confidentiality, but still maintained an audit trail.

The pharmacy provided both a private and NHS flu vaccination service. And the pharmacist had completed up-to-date training. And a certificate of recent training was seen. The pharmacy had up-to-date patient group directions (PGDs) for both services. The pharmacist had a 'flu vaccination' basket, which contained all consumables needed to provide the service. And some adrenalin ampoules and associated needles for administration, in case of anaphylaxis. He kept this basket in the dispensary and transferred this and the sharps bin to the consultation room when providing the service. This was to ensure only essential items were kept in the consultation room at all times. The pharmacist explained how the service was popular with people. And the number of people that accessed the service had increased year on year. The pharmacy advertised the service with leaflets and a banner across the back of the pharmacy counter. And the team discussed the service with people who would benefit from vaccination when handing out prescriptions to them.

The pharmacy stored Pharmacy (P) medicines behind the pharmacy counter. And it had locked shutters to secure these medicines when the pharmacy wasn't open. It obtained its medicines and medical devices from a number of licenced wholesalers. It stored its medicines appropriately in dispensary drawers and on shelves. The CD cabinet and fridge were of a good size for the amount of stock stored there. The team kept out-of-date CDs clearly segregated from other CD stock. The team consistently recorded the maximum and minimum fridge temperature daily. And the records indicated the temperature was kept between two to eight degrees Celsius. And this was the case during the inspection. The pharmacy had medicinal waste bins stored in the dispensary. These were stored in front of the sink, but due to the size of the dispensary this was an appropriate place for them. The pharmacy had the required equipment to be able to implement the requirements of the Falsified Medicines Directive (FMD). And the system was linked to SecurMed. The pharmacy had SOPs relating to the requirements of FMD. And the team had decommissioned some prescriptions. But due to an issue with the scanner and the reliability of the system, the pharmacy team was not consistently decommissioning medicines as part of the dispensing process.

The pharmacy had a date checking schedule printed into the pharmacy audit book. And the team consistently completed date checking of the specified areas of the dispensary as indicated in the schedule. The team completed this weekly and signed in the book to confirm completion. No out-of-date medicines were found during a random check of the dispensary drawers. The pharmacy team annotated the date of opening on the packaging of liquid medicines, so when dispensing the team knew they were fit to use. The pharmacy had a SOP for handling drug alerts. The team received details of medicine recalls and safety alerts. And it kept printed copies in a folder, indicating the action taken. A copy of recent recalls were seen in the file. And they had been stamped and signed, indicating the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services provided. And it keeps the equipment well maintained. The team uses the equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy had reference resources and access to the internet to obtain up-to-date information. The team used clean, crown stamped glass measures for pouring liquids. It used suitable equipment, such as rollers for the assembly of compliance packs. The pharmacy provided a free blood pressure monitoring service in the consultation room. And it had an Omron blood pressure (BP) machine, that looked new. And the pharmacist confirmed this was replaced yearly. The pharmacy had a health check machine situated to one side of the pharmacy counter. The pharmacist described how the external company regularly maintained the machine. People paid for the service. The team helped people use the machine and discussed the readings with them.

The pharmacy's computers were password protected. And the screens locked to prevent unauthorised access to people's private information. The computers were situated in the dispensary away from public view. It kept prescriptions awaiting collection in the dispensary. And this protected people's confidential information.

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.