

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 1 Station Road, ASHINGTON, Northumberland, NE63 9UZ

Pharmacy reference: 1035818

Type of pharmacy: Community

Date of inspection: 29/11/2022

Pharmacy context

This community pharmacy is in a Superdrug store in the centre of Ashington, a large town near Newcastle. Its main activities are dispensing NHS prescriptions and selling over-the-counter products. The pharmacy delivers medication to some people in their homes, and it supplies several people with their medication in multi-compartment compliance packs to help them to take their medicines. It also provides the 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

The pharmacy identifies and manages the risks associated with its services well. It has up-to-date written procedures that the pharmacy team follows. And it completes the records it needs to by law. Team members suitably protect people's confidential information and they understand their role to help protect vulnerable people. The team members respond appropriately when mistakes happen, they openly discuss what happened and take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. The team members accessed the SOPs and answered a few questions to confirm they had read and understood them. The team members received notification of new SOPs or when changes were made to existing SOPs. They demonstrated a clear understanding of their roles and worked within the scope of their role. And they were aware of what could and could not be done in the absence of the Responsible Pharmacist (RP).

The pharmacy had a procedure to record and learn from errors made during the dispensing process known as near misses. The pharmacist discussed the error with the team member involved and asked them to record it. They identified that the electronic record for capturing near miss errors was not always used. So, a paper version was implemented to ensure all errors were captured. A sample of near miss records showed that the details enabled the team to learn from the errors to help prevent the errors from happening again. The pharmacy completed electronic records of errors that reached the person, known as dispensing incidents and sent them to the head office team. The pharmacist manager undertook monthly reviews of the records and shared the outcome with team members. They discussed their errors and the changes they could make to prevent future errors. Recent reviews had highlighted the importance of clearly separating the workspace for dispensing from the checking area. And the team had separated products that looked and sounded alike. The pharmacy had a complaints procedure and details of how to raise a concern were displayed on the company's website. People raised their concerns with the pharmacist manager and team members who investigated the matter. Any unresolved matters were escalated through the complaints procedure to the head office team.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy regularly checked the balance of CDs to identify any issues such as missed entries. The pharmacy had procedures to ensure people's confidential information was protected and the company website detailed the privacy policy. The team members regularly completed training on the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers and email addresses for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The delivery drivers reported concerns about the people they delivered to and the team took appropriate action, such as contacting the person's GP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with an appropriate range of skills and experience to support its services. Team members work well together, even under the pressure they sometimes feel. They suitably support each other in their day-to-day work. And they have opportunities to receive feedback and complete training so they can appropriately develop their knowledge and skills.

Inspector's evidence

A full-time pharmacist manager who was recently in post covered the opening hours with locum pharmacist cover when required. The pharmacy team consisted of two part-time pharmacy technicians, three part-time qualified dispensers and two part-time delivery drivers who had completed appropriate training. At the time of the inspection the regional manager who was a pharmacist, a locum pharmacist, the two pharmacy technicians and a locum dispenser were on duty.

The pharmacy team was facing some staffing challenges and at the time of the inspection the three dispensers were absent from work. During this time the team members reported to have struggled to manage the workload and often they were a few days behind with the processing of prescriptions. They worked well together and supported each other but often had to break away from tasks such as dispensing to help people presenting at the pharmacy counter. The pharmacy technicians had worked additional hours and had taken on some management responsibilities before the pharmacist manager was in post. Team members described how they were sometimes subjected to concerns directed towards them from people when there were delays to the supply of their medication.

The team members used company online training modules to keep their knowledge up to date and were offered protected time at work to complete the training. But due to the workload pressures they couldn't always use the protected time. The team read the newsletter sent from the Superintendent Pharmacist to keep up to date with information such as new pharmacy services. The pharmacy sometimes held meetings which enabled the team to discuss their workload and plan how to manage it. The pharmacy generally provided team members with formal performance reviews to give them a chance to receive individual feedback and discuss their development needs. And they were given informal feedback when appropriate. One of the pharmacy technicians had taken the opportunity to ask for and enrol onto the accuracy checking technician course.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services. The premises have adequate security arrangements to prevent unauthorised access to the pharmacy.

Inspector's evidence

The layout of the premises provided two rooms for the team to work from. The main dispensary area had limited workspace which the team generally managed well. But occasionally some baskets were piled on top of each other and some completed compliance packs waiting to be supplied were stored on top of each other. This created an increased risk of errors. The team was aware of this and had obtained magazine box files which they planned to use to separate the packs from each other. The pharmacy had a dedicated room for dispensing and storing the large number of multi-compartment compliance packs supplied to people. The room was an adequate size for this activity and the team ensured all available space was appropriately used.

The pharmacy premises were tidy and hygienic, there were separate sinks for the preparation of medicines and hand washing. In response to the COVID-19 pandemic the pharmacy had installed clear plastic screens on the pharmacy counter. The team mostly kept floor spaces clear to reduce the risk of trip hazards. And there was enough storage space for stock, assembled medicines and medical devices. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a sound-proof consultation room which the team used for private conversations with people and when providing services such as the flu vaccination.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easily accessible and help people to meet their healthcare needs. The team manages its services well and makes sure people receive their medicines when they need them. Team members support people with advice and healthcare information. They store medicines properly and they regularly carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step free entrance through the main store. The pharmacy kept a small range of healthcare information leaflets and team members directed people to other healthcare services when required. The team members provided people with clear advice on how to use their medicines. And they were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). They made sure people prescribed valproate who met the PPP criteria had the correct support and information. The pharmacy provided services such as the seasonal flu vaccination against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to administer the vaccine. The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And stored separately in baskets in the controlled drugs (CD) cabinet.

The pharmacy provided multi-compartment compliance packs to help around 100 people living at home to take their medicines. The pharmacy also provided medicines in compliance packs to local care homes. The two pharmacy technicians managed the service and they divided the preparation of the packs across the month. They usually ordered the prescriptions in advance of supply to allow time to deal with issues such as missing items. The care home teams provided up-to-date information on people's current treatment and medication needs for that month. The team kept a record of the completion of each stage of dispensing of the packs to help manage any queries. They delivered the packs to the care home teams several days before the next cycle started. So, the care home team had time to check the supply before the person needed their medication. The team usually recorded the descriptions of the products within the packs but didn't always supply the manufacturer's packaging leaflets. The pharmacy sometimes received copies of hospital discharge summaries which the team checked for changes or new items.

There was sufficient space to enable team members to separate the labelling, dispensing and checking of prescriptions. They used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. And a sample found that the team completed both boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. It kept a record of the deliveries made to people but only obtained a signature of receipt of supplies made to the care homes.

The pharmacy obtained medication from several reputable sources. Team members regularly checked the expiry dates on stock and kept a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date and no out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening. This

meant they could assess if medicines were still safe to use. Fridge temperatures were checked and recorded each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient-returned CDs separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. These were usually printed off and a record of the action taken was kept.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And it completed regular checks on its equipment such as the blood pressure meter to ensure it gave accurate information. The computers were password protected and access to people's records were restricted by the NHS smart card system. The pharmacy had cordless telephones to enable the team to hold private conversations with people. It stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, which had restricted public access.

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.