

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 4-5 St. Swithins Street,
WORCESTER, Worcestershire, WR1 2PY

Pharmacy reference: 1038908

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

This is a community pharmacy in the centre of the city of Worcester. A wide variety of people use the pharmacy. They dispense NHS and private prescriptions and sell over-the-counter medicines and several other beauty and health-related items. The pharmacy supplies medicines in multi-compartment compliance aids for a few vulnerable people in their own homes to help them to take their medicines.

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	Good practice	3.1	Good practice	The pharmacy looks highly professional. The work areas are clean, tidy and organised.
		3.2	Good practice	There is good signposting to a spacious consultation room so it is clear to people that there is somewhere private for them to talk.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a good range of services. Everyone can access these services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The working areas are tidy and organised. The pharmacy asks its customers for their views and uses the feedback to improve services. It keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people. But, they do not learn enough from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team generally identified and managed risks. But, there had been two strength errors in July 2019, one involving Epilim Chrono. Incident reports had been completed for these but no specific actions had been put in place to reduce similar recurrences. Near misses were recorded electronically which meant that, in order to do this, the person had to exit from the dispensing labelling function. Few were recorded which supported that the electronic recording may not encourage all near misses to be recorded. The pharmacy manager said that he would, in future, record the mistakes on paper, with sufficient information to allow any useful analysis, at the time the mistake was detected, and, then upload the data at a later date when it was quiet. The qualified dispenser seen was able to report on a mistake the day before the visit involving co-codamol. The 15/500 mg strength had been picked instead of the 30/500. She said that the patient had had a change in dose and that she had labelled the medicines from the patient's prescription medication record and not from the prescription. This mistake had not yet been entered electronically.

The dispensary was newly re-fitted. It was tidy and organised. There were labelling, assembly and checking areas. The multi-compartment compliance aids were assembled when it was quiet and checked immediately to keep the benches as clear as possible. The pharmacist was required to do some self-checking. He was aware of this risk and said that he endeavoured to have a mental break between the assembly process and the checking process. A scanner to check for falsified medicines was linked to the labelling function and this reduced the risk of picking errors.

Baskets were used and red baskets distinguished the prescriptions for patients who were waiting. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years, or sooner if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff member seen was clear about her role. The company's sales protocol was displayed. The questions to be asked of patients requesting to buy medicines was displayed on the till. Close by, items that should be referred to the pharmacist, such as 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, 'red flag symptoms' and certain patient groups were also displayed. The NVQ2 qualified dispenser seen said that she would refer requests for multiple sales of codeine-containing medicines and Phenergan for young children to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was actively encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 100

% of customers who completed the questionnaire were satisfied with the service they received from the pharmacy. Most of the recent feedback was about the availability of stock, such as, hormone replacement therapy patches. The pharmacist contacted the surgeries to get the prescriptions changed to suitable alternatives that were available.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 January 2020 was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, fridge temperature records and date checking records were all in order. The pharmacy had not supplied any special obtain items for a very long time but there was a dedicated folder for this, if necessary.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The procedures to follow in the event of a safeguarding concern, about either a child or vulnerable adult, had been signed by all the staff. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely and they are actively trying to recruit a further team member. The company provides help when people are on holiday or off sick. The team members are encouraged to keep their skills up to date but they generally do this in their own time. Team members who are in training are well supported.

Inspector's evidence

The pharmacy was in the centre of the city of Worcester. They dispensed approximately 2,000 NHS prescription items each month. Due to the location, there were several acute 'walk-in' patients. 20 domiciliary patients had their medicines in compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager, one pre-registration student (not seen – on a study day), one full-time NVQ2 qualified dispenser, one newly appointed part-time medicine counter assistant (MCA) (in his induction phase) and one part-time driver. The staffing levels meant that the pharmacist sometimes had to self-check items (see under principle 1). But, the pharmacy was actively trying to recruit a part-time qualified dispenser which should ease this situation. There was limited flexibility for the staff to cover any unplanned absences. But, the staff reported that locum dispenser and locum pharmacist help would be secured if necessary. Planned leave was booked well in advance.

The staff seen clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed regular 'Edge' e-Learning and CPPE training, such as, recently on children's oral health. The dispenser seen said that she generally had to do this training at home because the low staffing levels meant that she had no time at work to complete this. The pre-registration student was well supported with learning. He spent almost every afternoon in the consultation room with work related to his course. He also had a study day every two weeks, as on the day of the visit, and, was due to attend a week's residential study course soon. The newly appointed part-time MCA was in his induction period and had dedicated time to read all the SOPs and to complete compulsory training. The dispenser seen said that she was supported to learn from errors. The pharmacist reported that all learning was documented on his continuing professional development (CPD) records.

The manager had been in post for just six months. Currently there were no regular staff meetings but he said that he hoped to initiate monthly meetings. He said that he was set targets, such as for Medicines Use Reviews (MURs), but that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✓ Good practice

Summary findings

The pharmacy looks highly professional. The work areas are clean, tidy and organised. There is good signposting to a spacious consultation room so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a highly professional image. It had been newly re-fitted, two years ago. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained.

The consultation room was spacious and well signposted. It contained a computer, a sink and two chairs. Conversations in the consultation room could not be overheard. The computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. The general medicines aisle was located in the close vicinity of the pharmacy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a good range of services. Everyone can access these services. The services are effectively managed to make sure that they are provided safely. The pharmacy team make sure that people are given the information that they need to use their medicines safely and effectively. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team make sure that people only get devices or medicines that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with automatic opening front door to the store. There was access to Google translate on the pharmacy computers for use by non-English speakers and the pharmacy manager spoke Polish. The pharmacy could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMRs), emergency hormonal contraception (EHC), supervised consumption of methadone and buprenorphine (but currently no clients), needle exchange and seasonal flu vaccinations. The later was also offered under a private agreement as was period delay, malaria prophylaxis (Malarone and doxycycline) and a company on-line prescribing service. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service and the private services. He consulted the NaTHNac website to provide up to date and appropriate advice on malaria prophylaxis.

20 domiciliary patients received their medicines in compliance aids. These were assembled daily when it was quiet. The trays were checked immediately to keep the workbench as clear as possible. There was a clear dispensing log for these patients and dedicated folders where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. The pharmacy ordered the prescriptions on behalf of these patients and there was a robust audit trail of what had been ordered. The assembled dosettes were stored tidily above the workbench.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were checked with the patient on hand-out. The staff seen were aware of the new sodium valproate guidance. Two female patients, who may become pregnant, had been identified. Guidance cards were included with each prescription for them.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted

to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at ordering, labelling and hand-out. Any patients giving rise to concerns were targeted for counselling. Suitable patients were encouraged to use the company's managed repeat prescription service to reduce wastage, to optimise the use of medicines and to identify any non-adherence concerns. The pharmacist reported that he frequently identified during MURs that patients did not know about the timings of their medicines and the inhaler techniques for some of the new powder inhalers.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Invoices for all these suppliers were available. The pharmacy had a scanner to check for falsified medicines as required by the Falsified Medicines Directive. This was linked to the labelling software and so reduced the risk of picking errors. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned or out-of-date CDs. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Dedicated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. Any required actions were recorded.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 500ml). There were two tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.