General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 35-39 Low Street, KEIGHLEY, West Yorkshire, BD21 3PP

Pharmacy reference: 1039652

Type of pharmacy: Community

Date of inspection: 30/09/2019

Pharmacy context

The pharmacy is in a shopping centre in Keighley town centre. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide seasonal flu vaccinations and supply medicines to people in multi-compartmental compliance packs. They provide a substance misuse service.

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	2.2	Good practice	Pharmacy team members regularly undertake training relevant to their roles. They reflect on their own performance, discussing any training needs with the pharmacist and other team members. And, new pharmacy team members complete a detailed induction programme.
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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks. The pharmacy protects people's confidential information. And, it keeps the records it must by law. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They listen to feedback from people and make changes to improve the quality of their services. Pharmacy team members record and discuss mistakes that happen when dispensing. But, they don't always discuss or record much detail about the causes of mistakes. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) available electronically. And the superintendent pharmacist reviewed them regularly. The sample checked were last reviewed in November 2017. And the next review was scheduled for November 2019. Pharmacy team members had read SOPs since the last review. And, their understanding had been documented using the electronic system. The pharmacy defined the roles of the pharmacy team members in each SOP. And, these were defined further in a colour coded chart, detailing which SOPs were relevant to each level of qualification.

The pharmacy provided flu vaccinations to people. It had signed PGD documents available. The pharmacist had completed theoretical training and physical vaccinations training. They were required to update their training every year. And, they had a completed declaration of competence available. The pharmacist explained that due to a pharmacy team member leaving, there were times during the week when they worked with a trainee staff member. They had identified the risk of a trainee not being sure what to do if there was an emergency with someone receiving a vaccination. So, the pharmacist was booking vaccination appointments, so these could be carried out when there was a trained and experienced member of staff available to help. The pharmacist said this was a temporary measure until the new pharmacy team member had been properly trained and had more experience. The pharmacist had completed a visual assessment of the other risks associated with providing the service. But, they had not documented their assessment. They explained that one identified risk had been that the bin to dispose of contaminated needles was being kept on the floor in the consultation room. They kept the consultation room locked when not in use. But, they were still concerned that a child might be able to reach inside the container if they were in the consultation room. So, they moved the bin to a higher shelf in the consultation room, so it was still accessible during a vaccination but could not be reached by children who accompanied an adult.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing or not checking their work caused the mistakes. And, their most common change after a mistake was to be more careful next time. Near miss errors were recorded electronically. And, the computer system provided a report of the analysis of the data collected about mistakes every month. The analysis provided was brief and was based on quantitative information, such as the number of different types of error occurring. There was no analysis for patterns of cause. But, pharmacy team members made changes to help prevent mistakes happening again. For example, they attached alert stickers to sections

in the drawers where they kept medicines that had been involved in errors. And, they separated look alike and sound alike (LASA) medicines that had been picked in error. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic reporting system. And, pharmacy team members printed a copy of each report to keep in the pharmacy. The examples of reports seen gave details of the error. But, pharmacy team members did not record much detail about the causes. One example was when a pharmacy team member had placed medicines for two people with similar names in to the same bag. They had discussed the error and changed the way they sorted electronic prescriptions tokens. And, to separate prescriptions for people with similar names so they were not kept in baskets next to each other.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise the company complaints procedure to people in the retail area. So, people might not know how to give the pharmacy feedback or raise a concern. It collected feedback from people by using questionnaires. And, it had some analysis available from the last set of questionnaires. One improvement point from people was to provide more information about stopping smoking. So, pharmacy team members had run a stop smoking health promotion campaign in their store to help raise awareness of the dangers of smoking and what the pharmacy could offer people to help them quit. The pharmacist gave an example of one person who had asked for advice during the campaign. The person suffered from chronic lung disease. So, pharmacy team members gave her advice about the benefits of quitting and how she could get help. The person had since returned to the pharmacy with a prescription for nicotine replacement therapy and had told pharmacy team members how much better she felt.

The pharmacy had up-to-date professional indemnity insurance in place. It had a current certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected by a contractor and sent for secure destruction. Pharmacy team members had completed training to protect privacy and confidentiality. They renewed their training every six months. And, they were clear about how important it was to protect confidentiality. The pharmacy had a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). Pharmacy team members read the procedure each year. And, they were required to pass an assessment after reading the procedure to test their knowledge.

Pharmacy team members were asked about safeguarding. They gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And, would refer to head office, who would then discuss with them how best to report the concern further. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members completed training every year. And, the pharmacist completed additional training via the Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They regularly undertake training relevant to their roles. And, they reflect on their own performance, discussing any training needs with the pharmacist and other team members. New pharmacy team members complete a detailed induction programme. And, pharmacy team members support each other to reach their goals. They feel comfortable discussing ideas and any concerns about the pharmacy's ways of working. And they work well together to resolve any issues.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and a trainee dispenser. Pharmacy team members completed e-learning training modules each week. The modules covered various topics, Recent examples had covered modern slavery and various new over-the-counter products. And, another recent module had refreshed the team's knowledge of age restricted products after an incident had occurred at another branch. Pharmacy team members were given time each week to complete their online training. In addition to training modules, pharmacy team members read new and updated standard operating procedures (SOPs) via the e-learning platform. They completed a quiz after each learning module and SOP to test their knowledge. The pass mark for each quiz varied. But, the pharmacist explained that if someone failed the assessment, they would be given time to retrain and she would support them to address any gaps in their knowledge, before re-taking the quiz. Pharmacy team members received a personal development review (PDR) every year with the pharmacist. They discussed various aspects of their performance, including what they felt they had done well and areas where they could improve. And, they set objectives in five different areas to help them achieve their objective. Four areas were objectives that related to delivering the pharmacy's targets. The fifth objective was a personal objective. The pharmacist provided some records of recent PDRs and the objectives set. In the samples seen, the pharmacy team member's personal objectives also related to achieving the pharmacy's targets, rather than them being personal development objectives as described. One example was for the pharmacy team member to focus on asking people to nominate the pharmacy to receive their electronic prescriptions. This was discussed with the pharmacist. And, she agreed that it would be helpful to reserve the fifth objective for something that was a personal goal for the pharmacy team member.

New pharmacy team members completed an induction, called 'Star in the Making'. The induction programme included requirements for new team members to read and understand all the SOPs relevant to their role. And, complete mandatory training modules on various subjects, such as safeguarding, the General Data Protection Regulations (GDPR), age related products and sales ('Challenge 25'), and fire safety. The pharmacist explained that the induction programme was split in to sections, each with a different timescale for completion. Some tasks had to be completed in the person's first shift, some in the second shift and others within the first two weeks of employment. She also said that new pharmacy team members were not allowed to work anywhere in the pharmacy unsupervised until they had successfully completed their induction programme.

The dispenser explained that she would raise professional concerns with the pharmacist or area manager. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing

policy. But, some pharmacy team members were unsure how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. And, the trainee dispenser was heard giving sound advice to people about over-the-counter medicines. And, asking the pharmacist for advice where needed. The pharmacy owners and superintendent pharmacist asked the team to achieve targets in various areas of the pharmacy business. For example, the number of Medicines Use Review (MUR) consultations completed, income generated from service delivered, sales of pharmacy medicines, and the number of people nominating the pharmacy to receive their electronic prescriptions. The pharmacist said targets were realistic and achievable. And, targets were discussed at a weekly conference call between other managers in the region and their area manager. During the call, people shared their experiences of achieving targets. And, they suggested and discussed improvements to help support pharmacies that weren't meeting their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet elsewhere in the store, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is easily accessible to people, including people using wheelchairs. It has systems in place to help provide its services safely and effectively. And, it stores, sources and manages its medicines safely. Pharmacy team members use the available technology to help reduce the risks during the dispensing process. They dispense medicines into devices to help people remember to take them correctly. And, they provide these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they give these people advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the shopping centre. Pharmacy team members said they would use written communication with someone with a hearing impairment. And, they were able to provide large-print labels to people with a visual impairment. The pharmacy ran various health promotion campaigns throughout the year. And, these were aligned to local and national campaigns. Before each campaign, pharmacy team members completed a plan to help design the campaign and to establish any resources that were required. They ran each campaign for one month.

The pharmacy supplied medicines to people in multi-compartmental compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take the medicines. Pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. And, they provided people with patient information leaflets about their medicines with each pack provided. Pharmacy team members documented any changes to medicines provided in packs on the patient's master record. But, they did not record detail of the prescriber who had made the changes. And, some master sheets seen were cluttered with changes, where pharmacy team members had scribbled old medicines and dosage instructions out and writing new information alongside. This was discussed with the pharmacist. And, she gave an assurance that pharmacy team members would make a new master sheet each time a change was made to help keep clearer records.

The pharmacy had recently had a trained dispenser leave. So, at certain times during the week, the pharmacist and a trainee dispenser staffed the pharmacy. The pharmacist explained that to minimise the risks of mistakes during these times, the dispenser picked the medicines according to the prescriptions. The pharmacist scanned each prescription. Then, she scanned each product picked by the trainee. If the product did not match the item on the prescription, the computer alerted the pharmacist. And, the computer would not allow dispensing to proceed or labels to be generated until the correct product had been scanned. Once the labels had been generated, the trainee dispenser attached these to the medicines and performed an accuracy check. Then, the pharmacist performed a final accuracy check of the assembled prescriptions. Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. And, they used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to twelve months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their

month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. The pharmacy obtained medicines from two licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct.

The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, she said she would check if the person was aware of the risks if they became pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy had a stock of information material to give to people to help them manage the risks of taking valproate. And, pharmacy team members provided printed material to people at risk each time they received a prescription for valproate. Pharmacy team members were aware of the requirements of the Falsified Medicines Directive (FMD). The had completed training. And, the pharmacy had the necessary software and equipment to be able to scan compliant products. The pharmacist explained that the system was being trialled locally and the pharmacy was waiting for a further rollout before implementing their systems.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. Pharmacy team members used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And these were password protected. Pharmacy team members stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge that was in good working order. And, pharmacy team members team used it to store medicines only. They restricted access to all equipment and stored all items securely.

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.