General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 31-35 The Merrion Centre, LEEDS, West Yorkshire, LS2 8NG

Pharmacy reference: 1039773

Type of pharmacy: Community

Date of inspection: 11/07/2019

Pharmacy context

The pharmacy is at the rear of a Superdrug store within a shopping centre in Leeds city centre. The pharmacy dispenses NHS and private prescriptions. And it supplies medication in multi-compartmental compliance packs to help people take their medicines. The Superdrug store has a nurse clinic next to the pharmacy. This provides a private vaccination service such as travel 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 generally identifies and effectively manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures and its team members follow them. It also has adequate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy team members usually respond appropriately when errors happen. They generally take the action needed to prevent similar mistakes happening again. Although they don't fully record all their errors. So, the team does not have information to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy kept the SOPs electronically and the pharmacist manager printed them off for reference. The pharmacy team read the SOPs and completed a test to show their understanding. The pharmacist manager monitored completion of this for each member of the team. The pharmacy had up to date Indemnity insurance.

The pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. So, the team members didn't have the opportunity to identify their own errors. The team member involved made an electronic record of the error. The entries captured causative factors from a drop-down list and a free type section recorded learning outcomes. A sample of records looked at showed that the pharmacy team members didn't always record the details about the prescription and dispensed item to help spot patterns. And they captured little information on the cause and learning points. The pharmacy kept electronic records of dispensing incidents. The team printed these reports for reference.

The pharmacy undertook a monthly patient safety review to spot patterns and make changes to processes. A sample of reviews looked at provided little information on patterns with dispensing errors. And most reviews provided limited details on the actions the team took to prevent similar errors. Most reports stated the action as double checking the prescription. The nurse from the private clinic used the same system to record incidents such as anaphylactic reactions to the vaccines. This information linked with the pharmacy errors and formed most of the patient safety issues. So, it was not always clear from the review if the error was related to the pharmacy. The pharmacy completed an annual patient safety report. The latest one described an error with the wrong directions on a label. The report explained that the team were asked to be more accurate. And to always check the details on the label before printing it off. The report stated that correct directions on the label meant that the person would use the medicine correctly. The report stated that the team were to be careful when picking products such as bendroflumethiazide 2.5mg and 5mg. And to separate medicines that looked and sounded alike. The report detailed reminders given to the team to always check the dispensed medicine against the label and the prescription. The pharmacist manager shared the outcome of the monthly and annual patient safety reviews with the team.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And displayed the results in the retail area.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had received training on the General Data Protection Regulations (GDPR) and had a privacy policy dated June 2019. The pharmacy did not display a privacy notice in line with the requirements of GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and contact numbers for local safeguarding teams. The pharmacist manager had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team members had not had the occasion to report a safeguarding concern. But they knew what to look out for.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the qualifications and skills they need to provide safe and efficient services. They receive feedback about their performance and discuss how they can make improvements. They are also given opportunities to complete more training and so keep their skills and knowledge up to date.

Inspector's evidence

The full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided cover for the remaining hours. The pharmacy team consisted of two part-time qualified dispensers, and a part-time medicines counter assistant. At the time of the inspection the pharmacist manager and one of the dispensers were on duty. The pharmacy displayed the training certificates.

The pharmacy provided extra training through e-Learning modules on a range of topics including new products. The pharmacy provided regular performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The team had time to reflect on their performance before the review meeting. The pharmacy did not hold team meetings. The pharmacist manager spoke individually to team members to ensure they received key pieces of information. The pharmacy had a whistleblowing policy. Team members could suggest changes to processes or new ideas of working. One of the dispensers had suggested labelling the baskets holding dispensed prescriptions waiting to be checked. So, the team could easily find the prescription when the person presented to collect it.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. And it has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room didn’t have a sink. But the pharmacy had alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs and manages its services well. It gets its medicines from reputable sources and generally stores and manages its medicines appropriately. Although its team members do not always write the description of medicines supplied in multi-compartmental compliance packs to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy via the store entrance. A display in the store window detailed the services offered. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges.

The pharmacy provided multi-compartmental compliance packs to help six people take their medicines. One of the qualified dispensers managed the service. And got support from others in the team. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. The team did not record the descriptions of the products within the packs. But it did supply the manufacturer’s patient information leaflets. The team stored completed packs on a dedicated set of shelves with a basket holding the empty packs of the medication dispensed in to the packs. So, the pharmacist could refer to the empty containers when checking the packs. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And separated people’s doses to reduce the risk of selecting the wrong one.

The team members provided a repeat prescription ordering service. They used a filing system to remind them when they had to request the prescription. The team usually ordered the prescriptions a week before supply via email or fax. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team members used a book to record when they had requested the prescriptions. The record included the medicines ordered. The team regularly checked the record to identify missing prescriptions and chase them up with the GP team. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The team regularly liaised with a GP team who sent prescriptions as faxes to remind them to post the original prescriptions. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). This had not found anyone who fitted the PPP criteria. The pharmacy had the PPP information cards and leaflets to pass on to people. The team used the electronic patient medication record (PMR) to record information received about people on high risk medication such as warfarin.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The

pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. Occasionally the pharmacist had to dispense and check their own work. On these occasions the pharmacist incorporated a break between dispensing and checking. This helped to identify any errors.

The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the prescription to refer to when dispensing and checking the remaining quantity. The team usually rang the wholesaler to check if the medicine would be available, and if not when it would be. So, they could pass this on to the person.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a large coloured sticker to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members did not always record the date of opening on liquids. This meant they may not identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Oramorph oral solution with 90 days use once opened didn't have a date of opening recorded. The team recorded fridge temperatures each day. A sample looked at 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 controlled drugs (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 had information, procedures and equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via internal email. The pharmacist manager also received email alerts on their own phone. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy used an Omron monitor for measuring people's blood pressure. The pharmacy completed safety checks on the electronic equipment.

The computers were password protected and access to people's records restricted by the NHS smartcard system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.