

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, Unit 4 Butterfly Walk,
Camberwell Green, LONDON, SE5 8RW

Pharmacy reference: 1040769

Type of pharmacy: Community

Date of inspection: 21/09/2022

Pharmacy context

This pharmacy is located within a small shopping centre in South-East London. The pharmacy serves people of all age ranges and provides blood pressure checks and the New Medicine Service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing 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	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 adequately manages the risks associated with its services. It keeps the records it needs to by law, so it can show that supplies are made safely and legally. People who use the pharmacy can provide feedback and the pharmacy team have received training to help protect the welfare of vulnerable people. When a dispensing mistake occurs, team members generally react appropriately.

Inspector's evidence

The pharmacy team said that they had coped well throughout the pandemic although the pharmacy had not had a regular pharmacist for some time. Some members of the team had taken time off during the pandemic, but this had not affected the workload as one of the regular dispensers had managed with a locum pharmacist. The pharmacy had closed for lunch during the pandemic and had suspended some services, such as Medicine Use Reviews, to help manage its workload. Services were now back to normal.

The pharmacy's standard operating procedures (SOPs) were held on the company's online portal, but some team members were not able to access these. The dispensers said that they had read the SOPs but did not know how to access them once they were read. The locum pharmacist had not seen the company's SOPs. Team members said they would find out how to access the SOPs and print hard copies out for easy access.

The dispensers said that near misses, where a dispensing mistake was identified before the medicine was handed to a person, were documented on the company's online healthcare safety portal. Controlled drug (CD) discrepancies, patient complaints, safeguarding concerns were also documented on this portal. One near miss was seen to have been recorded in August 2022, though this appeared to be a dispensing mistake which had reached a person. The pharmacy team said they would record these on the appropriate form in the future. No other near misses had been documented over several months checked. Team members said that they made sure that bag labels were stapled onto the bags as there had been instances where the bag labels had fallen off the bags.

The pharmacy had current indemnity insurance cover. An incorrect responsible pharmacist (RP) notice was displayed. This was changed to the correct sign during the inspection. Samples of the RP record were seen to be well maintained. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for private prescriptions, emergency supplies and unlicensed medicines. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

People were able to give feedback or raise concerns verbally, online, or by scanning a QR code displayed on the counters. The pharmacy normally conducted annual patient satisfaction questionnaires but had not done these since the start of the pandemic. Team members said they had experienced verbal abuse but had also received positive feedback and gifts from some of their patients. Team members said that they tried to keep more stock in after receiving complaints about stock levels of over-the-counter medicines.

Members of the team had completed training on information governance and the General Data Protection Regulation. Confidential waste was collected in separate waste bags and stored in lockable cages until collection by head office. Computers were password protected and smartcards were used to access the pharmacy's electronic records. A consultation room was available for private conversations and was not used to store any patient sensitive information.

Team members had completed online training on safeguarding, and most recently on the Ask for ANI initiative. They described a concern that the previous pharmacist had reported and said they would speak to the pharmacist if they had any safeguarding concerns. The contact details of the local safeguarding team were displayed in the dispensary, but the team did not know how up to date the details were. The dispenser said she would review these and update them if necessary.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Team members have access to training materials to help keep their skills and knowledge up to date.

Inspector's evidence

There was a locum pharmacist and two dispensers working during the inspection. They worked well together and communicated effectively. Another dispenser and a trainee medicine counter assistant worked at the pharmacy. All members of the team had either completed the relevant training or were enrolled onto a course. Team members felt there was sufficient cover for the services provided, though it was a struggle without a regular pharmacist. They said that people also felt more comfortable dealing with a regular pharmacist rather than speak to a different one every time. This was not having a major impact on the workload as the dispensers had been working at the branch for some time and appeared to take ownership at work. For example, one of the dispensers was involved in carrying out tasks normally reserved for pharmacy managers, such as the daily and weekly audits. This involved checking that certain tasks, such as CD stock checks and the completion of legal records were being done.

Team members tried to keep up to date by completing online modules on the company's portal. They were not provided with study time and normally completed training in their own time. One dispenser had recently completed a module on urinary tract infections. The other dispenser could not remember what training she had completed and could not access her training records. Team members said that they were emailed reminders to complete modules as and when they became available.

The dispensers described how they would undertake sales of over-the-counter medicines and refer to the pharmacist where necessary. One dispenser gave an example of where the sale of a pharmacy-only medicine had been declined.

Formal performance reviews were conducted once a year. Team members had the opportunity to discuss how they were getting on, any areas for improvement, learning needs, and issues. Some targets were set but team members said they struggled to meet these targets without a regular pharmacist at the pharmacy. They said there was some pressure to meet these targets, in the form of constant emails from the management team.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations. But team members could do more to ensure it is kept clean.

Inspector's evidence

The dispensary was located at the back of the shop. Screens were fitted at the medicines counter and access into the dispensary was via a lockable door. The dispensary was relatively narrow but there was sufficient work and storage space. Medicines were stored on shelves or in drawers. Fittings were relatively aged, and some shelves were dusty.

Team members said that the dispensary was cleaned at least once a day. This included wiping surfaces and emptying the bins. A cleaner was available at the shop but did not clean the dispensary. The ambient temperature and lighting were suitable for the services provided. A clean sink was available in the dispensary.

A small consultation room was available for private conversations or other services. The room was clearly signposted and easily accessible to people. But the floor was very dusty. A staff room and toilet were available for the pharmacy team.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely. And it orders its medicines from reputable sources and stores them properly. But it does not routinely highlight prescriptions for people taking higher-risk medicines. And this could mean that team members miss out on opportunities to provide these people with additional advice about how to take them safely.

Inspector's evidence

There was step-free access to the pharmacy and the main door was kept open. Services and opening times were clearly advertised, and team members described promoting some services, such as the New Medicine Service. Stickers were used to highlight prescriptions for people who were suitable for this service. Team members described ways in which they tried to make services accessible to people with disabilities or who did not speak English fluently.

Dispensing audit trails to identify who dispensed and checked medicines were completed. There was sufficient workspace and colour-coded baskets were used to prevent transfer between people and help the team manage their workload.

Prescriptions for higher-risk medicines, such as methotrexate and lithium, were not highlighted in any way. The pharmacy team did not carry out any checks to ensure people taking these medicines were being monitored and they did not provide any additional counselling and advice. The dispensers were aware of the valproate guidance but could not describe the 'at-risk' group correctly. They could not remember much from the guidance and gave assurances that they would re-read it. Valproate leaflets were available at the pharmacy.

Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The dispensers said they tried to clear uncollected prescriptions every four weeks.

The multi-compartment compliance pack service was managed by the dispensers. They kept a record of all prescription requests sent to the GP and followed them up if they were not received in a timely manner. Backing sheets were created once prescriptions were received and stock was picked against the prescriptions. Packs were assembled on a bench in the dispensary and kept aside for a few minutes for the pharmacist to check. If the pharmacist was not available, the packs were sealed and checked later. Prepared packs observed were labelled with product descriptions and mandatory warnings, but patient information leaflets were not always supplied. This could make it harder for people to have up-to-date information about their medicines.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team said they checked the expiry dates of medicines at regular intervals and kept clear records of this. No expired medicines were found on the shelves in a random check in the dispensary. The fridge temperature was monitored daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a

licensed waste carrier. Drug alerts and recalls were received electronically, actioned and filed for reference.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had several glass measures, with some used to measure certain liquids only. But they were not all clean. There were tablet counting triangles, including a separate triangle for cytotoxic medicines. This helped avoid cross-contamination. There was one fridge in the dispensary. Team members did not know how old the blood pressure monitor was or whether it had been calibrated or serviced. They said they would carry out the appropriate checks to ensure it was suitable for use. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources.

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.