General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 6b Aitken Street, LARGS, Ayrshire, KA30 8AU

Pharmacy reference: 1041867

Type of pharmacy: Community

Date of inspection: 16/03/2023

Pharmacy context

This is a community pharmacy on a main street in the seaside town of Largs near Greenock. Its main activities are dispensing NHS prescriptions and providing medicines to people in multi-compartment compliance packs to help them take their medicine correctly. It also sells medicines over the counter and provides services and advice under the NHS Pharmacy First 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 has suitable written procedures to help team members work safely and effectively. And it mostly keeps the records it must by law. Team members record and appropriately reflect on errors, and they share learnings to help drive improvements in working practice. They are aware of their responsibilities in keeping people's confidential information secure. And they have the knowledge to help protect vulnerable people using the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to guide team members to complete their tasks safely and effectively. Team members explained they accessed these via an online platform. And they completed a test to confirm their understanding and compliance with the SOP. Team members also had access to paper copies of the SOPs so they could easily refer to them if necessary.

The pharmacy team members recorded errors made and identified in the dispensing process known as near misses. They explained that errors identified by the responsible pharmacist (RP) were reviewed and recorded by the team member who made the error. Technology which allowed barcodes on medicines to be scanned against a prescription helped to keep the quantities of near misses low. Once a month, the records were reviewed by the pharmacist, or a nominated team member and learning points identified. Learnings were shared with team members informally on a Tuesday when most team members were present. And reviews were submitted electronically to the superintendent pharmacist's (SI) team so they could review and identify learnings. Team members explained they had implemented changes such as separating different pack sizes of the same medicine to reduce the frequency of incorrect selection. And they introduced a "ten basket rule" meaning they dispensed a maximum of ten prescriptions at a time to help keep good concentration and reduce complacency. Team members recorded errors identified after a person had received their medicine, known as a dispensing incident. They explained a recent dispensing error led to the incorrect medicine being delivered to a person. An incident review had been completed detailing the cause of the error and submitted to the SI pharmacist's team. The pharmacist explained learnings from the incident led to retraining the drivers in the SOP. And team members identified and highlighted deliveries with similar addresses which helped drivers pay extra attention to the information. The pharmacist explained changes had proven very beneficial as no further incidents of a similar nature had been identified.

Team members had clear job roles and responsibilities. They explained they knew what to do in the absence of the RP and they could refer to a SOP to support them if required. The RP notice was prominently displayed at the medicines counter and reflected the correct details of the pharmacist on duty.

The pharmacy had a complaints procedure. It was not displayed in the pharmacy, but team members explained people could access it online. Complaints were usually resolved in the first instance by the pharmacist. But if it could not be resolved, people were supplied with a telephone number for the company's head office customer service team. Team members explained they had access to an electronic system where they could report details of any potential complaints to the SI pharmacist's team. And they informed the regional manager of any potential complaints. The pharmacy had current professional indemnity insurance.

The pharmacy kept both paper and electronic records. The RP record was kept on paper and was completed accurately with the details of the RP on duty and when. The pharmacy dispensed private prescriptions to people and for animals. Records of supplies were kept electronically and were mostly completed accurately but some records were missing details of the prescriber. There were two private prescriptions from a prescriber in the EU. The pharmacist explained she had checked the registration status of the prescriber but had completed no further checks to ascertain the appropriateness of the treatment for this person. She had felt suitably satisfied to issue the medication to the person when they had arrived to collect it, but realised she could have made additional checks. The pharmacy supplied unlicensed medicines known as “specials”. It kept records known as certificates of conformity which detailed who prescribed the medicines and who received it. The pharmacy kept paper records of controlled drugs (CDs) and a sample seen complied with regulations. Team members carried out weekly checks of the CD stock held against the register running balance. A randomly selected medicine confirmed that the quantity held reflected the quantity in the register. And they kept records of patient CD returned stock.

Pharmacy team members completed company provided information governance and General Data Protection Regulation (GDPR) training annually. They were aware of their responsibilities surrounding confidentiality and kept confidential information separately. And this was transferred to the company’s head office for shredding. There was no privacy notice or information displayed in the pharmacy informing people how their data was used. Team members explained that the delivery driver was aware of his responsibilities surrounding confidential information when asking people to sign for their deliveries. This was achieved by asking people to sign the reverse of the delivery sheet so people could not see confidential information intended for the driver. The pharmacy team members had completed training in safeguarding vulnerable children and adults. And they were aware of their responsibilities to report any concerns. This included the delivery driver, who knew to report any concerns back to the pharmacist. Team members were able to refer to a document displayed in the dispensary which detailed the appropriate contact numbers if they had concerns. The RP, and resident pharmacists were members of the PVG scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably qualified team members who manage the workload safely and effectively. It has appropriate arrangements to supervise team members who are in training. And team members complete regular training relevant to their roles. They feel comfortable to raise concerns and make suggestions to improve working practices.

Inspector's evidence

Pharmacy team members at the time of the inspection included a regular locum pharmacist, a pharmacist manager, a pre-registration pharmacy technician, a dispenser and two medicines counter assistants. The pharmacy also had a further resident pharmacist, a dispenser, a medicines counter assistant, two trainee medicines counter assistants and three delivery drivers. Team members were observed to be working together safely and effectively managing workload. The pharmacy employed mainly part-time team members which meant holidays and absences were easier to cover.

Trainee team members working on the medicines counter were supervised by both the resident pharmacist and pharmacist manager on alternate Saturdays. Team members were encouraged to develop their learning. The trainee pharmacy technician was due to finish her course and planned to further her training by becoming an accuracy checking technician. Team members were provided with regular training by the company. And they explained this had covered both clinical topics such as new over the counter treatment for hayfever and regulatory topics such as “challenge 25” where people under the age of 25 are asked to provide ID for age restricted products. They explained they had protected learning time during working hours, but depending on workload, sometimes this was completed at home. Team members were observed referring questions to the pharmacist when they required help. They explained they knew how to manage repeated requests for medicines liable to abuse by referring to the pharmacist where necessary. The pharmacist explained how he would refer a person to their GP if necessary.

Pharmacy team members felt comfortable to discuss their mistakes and share learnings to drive improvements. And complaints and feedback were shared with team members. They received yearly reviews to discuss the previous year and set new objectives for the upcoming year. The pharmacist explained she received a review every six months. Team members felt comfortable raising any concerns with the pharmacy manager and resident pharmacist. And they knew how to escalate issues to the regional manager or SI team if necessary. Team members worked to some targets. And explained how they exercised discretion for meeting the targets to ensure people's healthcare needs were met.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and tidy and provide suitable space for the services provided. It has a suitably sized soundproofed room where people can have private conversations with team members and access services with the pharmacist.

Inspector's evidence

The pharmacy was clean, tidy, and well organised. And team members cleaned the pharmacy daily. The dispensary was small but there was bench space available for separate tasks to be completed and the floor was free from trip hazards. Team members made use of a separate room to dispense and store multi-compartment compliance packs. And this room could be viewed from the dispensary via a hatch. Access to the room was gained via the retail area and it was secured when not in use.

The pharmacy had a soundproofed room which had space for the pharmacist to accomodate both people and their representatives comfortably, if necessary. The room also had a hatch which was used for supervision of medicines. And services such as administration of vaccinations were carried out in the room. The dispensary was positioned at a higher level than the medicines counter so team members could see people waiting to access services. And pharmacists worked at a bench directly behind the medicines counter so were able to intervene in conversations to provide advice if necessary. There was a sink in the dispensary that provided cold water for professional use and hot water for hand washing. Team members and members of the public had access to hand sanitiser. Lighting was appropriate but at the time of the inspection, there was a broken light in the dispensary which team members explained had been discovered that morning and was still to be reported.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services safely and effectively. And people easily access its services. Team members keep good records to help ensure people receive their medicines when they need them. And they have appropriate conversations with people to help them take their medicines properly. Team members store and manage medicines as they should.

Inspector's evidence

The pharmacy was positioned at the rear of a large retail store. And there was level access from the street for people with limited mobility and with pushchairs. The pharmacy team delivered various NHS pharmacy services such as the Pharmacy First service, smoking cessation, and emergency hormonal contraception. The pharmacist manager and resident pharmacist had signed documentation to confirm their compliance with patient group directions (PGDs) which guided and supported them to provide the services safely and effectively. The pharmacist accessed up-to-date copies of the PGDs online. They pharmacy had previously printed copies but these were now out-of-date. The pharmacist subsequently confirmed up-to-date copies had been printed. The pharmacy provided a service where team members supervised doses of medicine to people. Team members explained they used an automated dispensing machine to measure doses. They prepared the medicine once a week and this helped them to manage workload.

The pharmacy used different tools to help deliver its services safely and effectively. Team members provided people who had a visual impairment with large print labels to help them read information on the labels of how to take their medicines. When dispensing, they kept people's prescriptions and medicines in baskets to reduce the risk of their medicines being mixed up. And they used stickers on prescriptions to highlight actions needed, such as interventions by the pharmacist, or the inclusion of a controlled drug or fridge line. Team members didn't always sign to say who was involved in which stage of the dispensing process, so there wasn't a complete audit. And it may be difficult to identify team members involved in errors to help their learning. Team members provided people with a note of any medication they did not have in stock. They kept these prescriptions separately and explained how they were checked twice a day upon receipt of a stock delivery so that people were not delayed in receiving their medication. And if necessary, they would liaise with the person's GP whether an alternative medicine was appropriate to be prescribed.

The pharmacy provided a delivery service, including delivering medication to people's homes on a nearby island. Team members explained the driver had a paper record of deliveries to be made that day. The driver asked people to sign the reverse of the sheet to confirm they had received their delivery, which meant that people's confidential information was kept secure. During the inspection, the team acted promptly to arrange an urgent delivery of a fridge line medicine with the driver. The driver prioritised the delivery to help prevent it being kept out of the fridge longer than necessary.

The pharmacy provided medicines in multi-compartment compliance packs to help people take their medicines properly. Team members explained they managed the process by ordering people's prescriptions four weekly. Each person had a folder which contained a list of the medication they took, and this was checked against the prescriptions. And any discrepancies queried with the GP surgery. The

pharmacy kept records of changes made by the person's GP as an audit trail in case of queries. Team members split the workload into four weeks and kept a list of which people received their pack on which day. This allowed team members to prioritise workload. Multi-compartment compliance packs were annotated with detailed descriptions of the medicines in the pack to help people identify their medicines. And patient information leaflets were supplied alongside the packs, so people had the required information about their medicines. Different people's packs were stored together, on top of each other, which may increase the risk of a team member selecting an incorrect pack for delivery.

The pharmacy sourced medicines from a number of recognised suppliers. Team members had a process to check the expiry date of medicines, using a matrix which detailed the section of the dispensary to be checked weekly. They created a list by month, of medication going out of date so they could remove it from the shelves before it expired. Liquid medicines with a short expiry date after opening were marked with the date of opening. Random sampling confirmed no out-of-date medicines. The pharmacy had two fridges which were checked twice daily and records confirmed the medicines were stored within the required 2-8 degrees. Medicines were stored neatly in the dispensary. CDs waiting to be supplied to people were kept separately from date-expired CDs and patient returned CDs to prevent them from being mixed up. The pharmacy kept CD denaturing kits to ensure that medicines were destroyed appropriately. And it stored patient returned medicines in medicinal waste bins which were kept separetely from routine stock.

Team members knew to obtain additional information when dispensing higher-risk medicines such as valproate, lithium, and warfarin. They used stickers during the dispensing process to highlight that people required additional counselling to help them take their medicines safely. They were aware of the additional counselling and patient cards to be given to people taking valproate in the at-risk category. And the pharmacist confirmed she had the required conversations with people when handing out their medication. Team members understood the procedure to manage drug alerts and medicine recalls. They received recalls by email, kept them in a folder once printed and team members signed to confirm the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy had appropriate equipment for its services. And it uses its equipment and facilities to maintain people’s privacy.

Inspector's evidence

The pharmacy had up-to-date reference sources including paper and electronic copies of the British National Formulary (BNF) and BNFc (for children). It had equipment to provide its services. This included a blood pressure monitor which had recently been replaced and had the date of first use recorded for team members to know when it needed calibrating or replacing. And equipment to provide vaccination services, including adrenaline ampoules and syringes which meant that pharmacists could appropriately respond to adverse reactions. The pharmacy had an automated machine for dispensing methadone. And this was calibrated before use. There were crown marked measuring cylinders used to measure water and liquid medicines. And these were marked to help prevent cross-contamination. Team members used triangles to count tablets, and these were cleaned after each use. They had a separate triangle used solely for cytotoxic medication. Computers were password protected to prevent unauthorised access. And they were positioned so that screens could only be seen by team members. Team members were able to keep telephone calls private due to the position of the telephone in the dispensary. Items awaiting collections were retained in drawers in the dispensary so people's private information couldn't been seen from the retail area.

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.