General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharamcy, Unit 1, 12-22 High Street, INVERNESS, Inverness-Shire, IV1 1HY

Pharmacy reference: 1042151

Type of pharmacy: Community

Date of inspection: 18/05/2023

Pharmacy context

This is a community pharmacy in Inverness. It dispenses NHS and private prescriptions including supplying medicines in multi-compartment compliance packs. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and review the pharmacy's processes and procedures. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. The company issued the SOPs via its online operating system. And emailed team members to alert them to new procedures which they read and annotated to show they followed them. Records showed that 'responsible pharmacist' and 'controlled drug' procedures were up to date and due to be reviewed in November 2023. The company contacted the 'responsible pharmacist' (RP) when team members had not read SOPs. And they acted on the information to ensure that team members read them to comply with the requirements of their roles and responsibilities. Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. Team members knew to record their own near miss errors on the company's safety portal. And the RP carried out regular reviews and discussed the errors and any patterns and trends to help them identify and manage dispensing risks. Team members used bar-code scanning technology to manage the risk of selection errors. And they had separated cetirizine and citalopram medications and antibiotics that started with C due to mix ups. The superintendent pharmacist's (SIs) monthly Clinical Excellence newsletter for May 2023 was displayed on the wall. And it included an article to remind team members to scan all packs to manage dispensing mistakes. It also highlighted mix-ups with risperidone and ropinirole medications. An area pharmacist manager contacted the RP every week to make sure the pharmacy was running safely and effectively. And they visited the pharmacy around every six months when they carried out auditing activities. Team members knew to report dispensing mistakes that people reported after they left the pharmacy to the pharmacist. And they produced a report using an electronic template which they sent to the (SIs) office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The pharmacy trained its team members to handle complaints. And the company provided a SOP for them to refer to.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 31 January 2024. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. Team members maintained the controlled drug (CD) registers and kept them up to date. And they evidenced that they carried out balance checks once a month. People returned controlled drugs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of 'specials' that were up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. And they used a

designated container to dispose of confidential waste which an approved provider collected for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And team members provided a few examples of when they had spoken to the pharmacist when they had cause for concern. The pharmacy had contact details for local agencies for ease of access.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had returned to what it had been before the coronavirus pandemic due to its city centre location. The 'responsible pharmacist' (RP) had recently conducted a review due to two team members leaving. And the company had authorised replacements to ensure the pharmacy continued to have the right number of team members with the necessary knowledge and skills for the services it provided. A long-serving RP worked at the pharmacy. And the other team members were long-serving and experienced in their roles and responsibilities. The following team members worked at the pharmacy; one full-time pharmacist, one full-time trainee pharmacy technician, one full-time dispenser, four part-time dispensers and one part-time delivery driver. The RP managed annual leave requests with only one team member permitted to take leave at the one time. A part-time team member who worked on a Saturday was available to work throughout the week to provide cover when required. Team members working patterns were displayed on the pharmacy wall. This provided an aide memoire for other team members to refer to. And helped to ensure the necessary tasks were completed.

New team members completed mandatory training during an induction period. This included health and safety training and reading the pharmacy's policies and procedures that were relevant to their roles and responsibilities. The company enrolled the new staff on qualification training. And the pharmacy provided protected learning time in the workplace so that team members completed mandatory and qualification training. This included keeping up to date with 'standard operating procedures' (SOPs) and completing pharmacovigilance training such as UK GDPR and safeguarding procedures. It also provided eight hours protected learning time to support a team member whilst they undertook qualification training to register as a pharmacy technician. The company provided locum pharmacists with access to SOPs. And it was mandatory for them to read and annotate them before working at the pharmacy.

The RP supported team members to learn and develop and keep up to date with changes and new initiatives. For example, they had discussed the pharmacy's NHS travel vaccination service. And this helped them to make bookings and gather information at the time over the phone. They had also completed anaphylaxis, CPR and emergency first aid training, so they knew how to manage incidents. The pharmacist was undergoing 'pharmacist independent prescriber' (PIP) training. And they had completed the necessary training so they were accredited and authorised to provide the NHS travel vaccination service. A dispenser's electronic training record showed they had completed training, and they were authorised to supply naloxone injections. They had also completed Nurofen for child fever training.

Team members had individual personal logon credentials to access learning. This included new SOPs and e-learning, and once completed the system updated individual learning records. Team members discussed the pharmacy's working practices to identify risks and the need for improvements. They had

identified the need to rearrange stock due to congestion and had moved eye drops and other items, so they were neat and tidy. This had managed the risk of selection errors. They had also re-organised serial prescription dispensing due to an increased number of prescriptions and workload. Team members knew their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy had conducted a recent risk assessment. And it had rearranged the pharmacy's working areas as a result, so that team members had adequate space to safely carry out the pharmacy's activities. A sound-proofed consultation room with a sink was available for use. And it provided a clinical environment for the administration of vaccinations and other services such as blood pressure monitoring. The consultation room also provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. A small separate hatch that faced into the consultation room was used to supervise the consumption of some medicines. Team members cleaned and sanitised the pharmacy regularly, and this ensured it remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take comfort breaks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

A step-free entrance provided access to the pharmacy, and this helped people with mobility difficulties. The pharmacist provided an NHS travel vaccination service via a range of 'patient group directions' (PGDs). And they also provided supplies of Malaria medication. The consultations lasted around 20 to 30 minutes and they saw only one person each day. This helped with service continuity for dispensing services. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. They checked expiry dates once a week and kept audit trails to evidence when checks were next due. This managed the risk of supplying short-dated stock in error. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug (CD) cabinets for some items and medicines were well-organised. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members produced an audit trail of drug alerts. And they evidenced they had checked for affected stock so it could be removed and quarantined straight away. This included a recent drug alert for Emerade injections. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. The pharmacy supplied original packs which contained patient information leaflets and information cards. And they had spare information cards in the event they needed to supply split packs.

Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. And this helped to manage the risk of items becoming mixed-up. The pharmacy supervised the consumption of some medicines for around the same number of people it had the previous year. And team members dispensed some doses using an automated dispensing machine. They obtained a clinical and accuracy check at the time of registering new prescriptions on the system. And the pharmacist carried out a final accuracy check at the time they made the supply. The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medication. And they used an upstairs area to assemble and store packs. The numbers had recently decreased due to a cap placed on the number of people registered with the service. Trackers helped team members to plan pack dispensing. And this ensured that people received their medications when they were due. They used supplementary records that provided a list of each person's current medication and dose times which they kept up to date. And they checked new prescriptions against the records for accuracy. Team members provided descriptions of medicines. And they supplied patient information leaflets for people

to refer to. Some people collected the packs either themselves or by a representative. And the team members monitored the collections to confirm they had been collected on time. Team members contacted the relevant authorities to raise concerns to ensure that people were receiving support when necessary. The pharmacy dispensed serial prescriptions for people that had registered with the 'medicines: care and review' service (MCR). The pharmacy had a system for managing dispensing so they could order items and dispense in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used an automated dispensing system to dispense methadone doses. And only authorised team members calibrated the system each morning to ensure accuracy of doses. The RP sometimes used a blood pressure monitor. And they renewed or calibrated the monitor to ensure it was accurate in its readings. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.