General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 69-73 The Mall, Arndale Shopping Centre, LUTON, Bedfordshire, LU1 2TJ

Pharmacy reference: 1073113

Type of pharmacy: Community

Date of inspection: 18/05/2023

Pharmacy context

The pharmacy is in a shopping centre in central Luton. It dispenses NHS and private prescriptions and provides health advice. Services include delivery, supervised consumption, blood pressure case-finding service, online doctor, community pharmacy consultation service (CPCS), discharge medicines service (DMS), new medicines service (NMS) and seasonal flu vaccinations. Health check and travel clinic medicines and vaccinations were available through the nurse-led clinic with a separate booking system.

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	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's working practices are safe and effective. The pharmacy team members manage the risks in providing services by following suitable written procedures. They review their mistakes so they can learn and improve the quality of the services. Members of the pharmacy team keep the records they need to, to show medicines are supplied safely and legally. They understand how to protect people's private information. And they know how to raise a concern to safeguard vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded their own near misses on the 'Risksured' website to learn from the mistakes and reduce the chances of them happening again. As the pharmacy did not have a full-time pharmacist at the time of the visit, a pharmacy manager from a neighbouring branch came to the pharmacy regularly and reviewed the near miss records to spot patterns or trends with the mistakes and discuss them with the pharmacy team. During a meeting the pharmacy's team members had agreed to introduce an additional check by dispensing assistants (DAs) before prescriptions were checked by the pharmacist. The pharmacist also double-checked controlled drugs (CDs) with a DA and the team made sure they informed the locum pharmacists about the extra check. A DA explained that medicines involved in incidents or were similar in some way (such as Epilim and Epilim Chrono) were separated from each other in the dispensary. This reduced the risk of errors when putting away medicines which had similar packaging. The pharmacy team recorded safety information on the pharmacy computer such as incidents involving injury, CD discrepancies, medicines abuse, customers attempting to buy large amounts of medicines over the counter (OTC) which were liable to misuse and safeguarding concerns identified by the team.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when picking products and then labelling them. They gave owing tickets for medicines which were outstanding. And assembled prescriptions were not handed out until they were clinically and finally checked by the responsible pharmacist (RP). Interactions between medicines prescribed for the same person were shown to the RP and any interventions were recorded on the patient medication record (PMR). The pharmacy team members highlighted any high-risk or new medicines which required additional counselling. They checked the person's name and date of birth to make sure they gave medicines to the correct people.

The pharmacy had standard operating procedures (SOPs) online for most of the services it provided. And these had been reviewed since the last inspection. Members of the pharmacy team were required to read the SOPs relevant to their roles to show they understood them and would follow them. And the pharmacy maintained training records for each team member. Members of the pharmacy team knew what they could and could not do and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist. The most recent SOP the team had trained in was an updated sales protocol. The pharmacy had a complaints procedure and people could

leave feedback via an annual survey or via a QR code.

Most pharmacy-related risk assessments were undertaken by the pharmacy’s head office. Information was entered on ‘Risksured’. Measures had been put in place to ensure business continuity and following an audit, the pharmacy had been provided with support through locum dispensers and recruiting new team members. The pharmacy also conducted clinical audits in line with the pharmacy quality scheme (PQS) and these included monitoring people prescribed anti-coagulants, asthma, antibiotics and sodium valproate.

The pharmacy displayed a notice that told people who the RP was and kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a key log and recorded fridge temperatures daily in the pharmacy audit book. The pharmacy had a CD register and CDs were audited weekly. The methadone register was electronic and linked to the Methameasure. A random check of the actual stock of one CD matched the recorded amount. The pharmacy kept records for the unlicensed medicinal products it supplied and it maintained an electronic register of the private prescriptions it dispensed. And these were generally in order. Emergency supplies were recorded on PharmOutcomes.

The pharmacy maintained a pharmacy business continuity plan so it could function during an emergency. The pharmacy was registered with the Information Commissioner’s Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy maintained an information governance (IG) folder containing information relating to confidentiality and general data protection regulation (GDPR). One of the team members described how they protected people’s personal information and made sure it was disposed of securely. They were using their own NHS Smartcards. The pharmacy’s computer system was password protected. The pharmacy had a safeguarding SOP. Members of the team had completed level 2 safeguarding and the RP had completed a level 3 safeguarding training course. They knew what to do and who to tell if they had concerns about the safety of a child or a vulnerable person. One team member described how the pharmacy had assisted in a safeguarding situation. The team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy supports its team with ongoing training to keep their knowledge and skills up to date. They work well together to manage the workload and they know how to raise concerns. They are comfortable when providing feedback about services to the pharmacist.

Inspector's evidence

The pharmacy had not had a permanent full-time pharmacist since the previous year, so it relied on locum pharmacists. The pharmacy team included three full-time dispensing assistants, one part-time trainee pharmacy assistant who was undertaking the Overseas Pharmacists' Assessment Programme (OSPAP), two part-time medicines counter assistants and a trained part-time delivery driver. The pharmacy relied upon its team to cover absences.

Members of the pharmacy team were provided with training topics relevant to their roles via an in-house training platform. The pharmacy monitored each team member's progress in completing training and protected learning time was allocated if necessary to ensure training was completed within a timeframe. The team had completed all the pharmacy quality scheme (PQS) training. The pharmacy manager from a neighbouring branch, visited the pharmacy regularly and provided support to the team members. They organised team meetings and shared news via a WhatsApp group.

The team worked well together. People were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew how to raise a concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, bright and secure. The pharmacy protects people's private information and keeps its medicines safe when it is closed.

Inspector's evidence

The registered pharmacy premises were bright and well signposted within the main store. The pharmacy had a retail area with a counter and the dispensary on a slightly higher level which gave a view over the medicines counter below. The pharmacy had a cubicle which provided privacy for clients who used the supervised consumption service. And there were two spacious consultation rooms which were locked when not in use. One was used by people wanting to have a private conversation with a team member and the other was where the nurse provided the travel vaccines clinic. Steps were taken to make sure the pharmacy and its team did not get too hot. The worksurfaces in the dispensary were cleaned on a rota basis by members of the pharmacy team.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easily accessible to people with a range of needs. Its working practices are safe and effective. It gets its medicines from reputable sources and stores them securely at the right temperature to make sure they are fit for purpose and safe to use. The pharmacy team knows what to do when medicines have to be returned to the suppliers. Members of the team give suitable advice to people about where they can get other support.

Inspector's evidence

The pharmacy was in-store with level access from the main covered walkway in the shopping centre. This made it easy for people who used a wheelchair or who had small children in a pushchair. The pharmacy team members tried to make sure people could use the pharmacy services. They could print large font labels which were easier to read and they could speak or understand Romanian, Vietnamese, Urdu, Bengali, Hindi and French to assist people whose first language was not English. The pharmacy displayed its opening hours and information about some of the services the pharmacy offered. Members of the pharmacy team signposted people to another provider if a service was not available at the pharmacy. At the time of the visit, the pharmacy was not supplying medicines in multi-compartment compliance packs. So, if people could not manage their medicines in their original packaging they were signposted to a pharmacy which did provide the service.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. Members of the pharmacy initialled dispensing labels so they could identify which of them prepared a prescription. They highlighted some prescriptions requiring a pharmacist to speak to the person about the medication they were collecting or if other items needed to be added. They were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. The RP explained counselling for people who were prescribed isotretinoin. The pharmacy gave alert cards with important information to people prescribed high-risk medicines. A number of clients accessed the pharmacy’s substance misuse service and there was a consultation room for those requiring supervised consumption. The pharmacy team members referred people to their doctors if they had been identified by the blood pressure case-finding service and fitted the criteria.

The pharmacy received referrals via PharmOutcomes for the community pharmacy consultation service (CPCS). The RP offered to provide the new medicines service (NMS) to people who were prescribed new medicines. The NMS helped people to take a new medicine prescribed to treat a long-term condition. Each winter people could have a flu vaccination at the pharmacy. The pharmacy had an online doctor service with a video consultation facility. If people were prescribed medication via the weight management service, they were required to attend the pharmacy to be weighed to monitor weight loss.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer’s packaging. The pharmacy team kept the dispensary tidy and checked the expiry dates of medicines and recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees

Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy team members cleared uncollected prescriptions every six weeks and contacted people to see if they still required the medicines. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy keeps people’s private information safe.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment if team members needed it. The pharmacy had a few glass measures for use with liquids, and some were used only with certain liquids. Methadone was dispensed from a Methameasure which was cleaned and recalibrated daily. The pharmacy team had access to up-to-date reference sources. The pharmacy had two fridges to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The pharmacy collected confidential waste for safe disposal. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members used their own NHS smartcards.

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.