General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 23 St. Georges Street, CANTERBURY, Kent, CT1 2SS

Pharmacy reference: 1080573

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

The pharmacy is in Canterbury town centre. It receives around 65% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service and administers the influenza vaccine using a patient group direction. The pharmacy provides multi-compartment compliance packs to around 25 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to around ten people and offers a needle exchange service.

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 generally identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. It generally keeps its records up to date. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of a mistake. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. And incidents were reported on the National Reporting and Learning System. A monthly patient safety report was produced and reviewed by head office. Team members were provided with learning points from this report. The area manager carried out governance and legal audits every six months, and one of these was done during the inspection. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The wrong medicine was collected by the delivery driver and the incident had been documented.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that she would contact the store manager if the pharmacist had not arrived in the morning. She confirmed that the pharmacy would remain closed and she could not access it. She knew that she should not sell pharmacy only medicines or hand out dispensed items if the pharmacist was absent from the premises.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The prescriber's address was not always recorded in the private prescription record. And the nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that he would ensure that the private prescription record and emergency supply record was completed correctly in future. All necessary information was recorded when a supply of an unlicensed special was made. Controlled drug (CD) running balances were checked around once a week. One CD liquid's balances were checked weekly; overage was recorded in the register. The address of the supplier was not routinely recorded in the CD registers. And the running balance had not been kept up to date for one liquid CD register for the last two days. There was one occasion recently when the balance had been below zero because there was a missed entry for a receipt of that liquid CD. The pharmacist said that he would ensure that

the CD record was updated promptly when stock was received or supplies were made. The responsible pharmacist (RP) log was largely completed correctly, but there were some gaps where the RP had not filled in the log. The area manager said that she would ensure that locum pharmacists completed the log for the days they were working. The correct RP notice was not displayed at the start of the inspection, but this was resolved.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and the pharmacist used his own Smartcard during the inspection. Dispensed items awaiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed annual General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results were generally positive with 100% of respondents satisfied with the staff being polite and taking time to listen. The pharmacy complaints procedure was available for team members to refer to if needed. The pharmacist said that he was not aware of any recent complaints. The area manager said that complaints were referred to her to deal with.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that he was not aware of any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and one dispenser working during the inspection. The area manager was at the pharmacy to carry out personal development reviews with the pharmacists. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The dispenser had completed an NVQ level 2 dispenser course. Team members were provided with monthly online training by the pharmacy and this was monitored by the area manager. The dispenser said that she completed training during quieter periods but could access it at home. But team members were not allocated protected training time during the working day. The pharmacist was undertaking training so that he could provide travel services and emergency hormonal contraception.

The dispenser explained that there were monthly team meetings held to discuss any issues. Team members had performance reviews and appraisals carried out by the area manager or the pharmacists. And the pharmacist carried out them for other team members. The dispenser said that she had a good working relationship with the pharmacist and she felt confident to discuss any issues with him. She said that she could also speak with the area manager directly.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that he carried out these services for the benefit of the people who use the pharmacy and he would not let the targets affect his professional judgement or decision making.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises largely provide a safe, secure, and largely clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. Pharmacy only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed.

The pharmacy was bright and tidy throughout. It was mostly clean, but the sink in the dispensary was stained. The dispenser said that she had attempted to clean it many times but she could not get rid of the stains. Air-conditioning was available in the main store but the air-conditioning in the pharmacy was not working. The area manager said it had been reported and was due to be fixed. The room temperature on the day of the inspection was suitable for storing medicines.

There were three chairs in the shop area for people to use. These were positioned near to the medicines counter which may increase the chance of conversations at the counter being overheard. There were two areas where people could have a private conversation with the pharmacist if needed.

The pharmacy's main consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. There was a separate screened off area which was primarily used for the supervision of people when they were taking their medicine and for the needle exchange service. There was a hatch from that area into the dispensary. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy largely provides its services safely and manages them well. It gets its medicines from reputable suppliers. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets were available. An induction hearing loop was available, but the dispenser was not sure if this was in good working order. She said that she would place it on charge and check it.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for schedule 3 and 4 CDs were not highlighted, but the dispenser knew that these were only valid for 28 days. The pharmacist said they checked CDs with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people in the at-risk group. But there were currently no people who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the valproate patient information leaflets or warning cards available. The pharmacist said that he would contact the manufacturer to order these.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was generally marked and recorded on lists for short dated stock. There were several packs of test strips which had expired in September 2018 found in with dispensing stock. These had not been marked. The pharmacist said that the auditors had said that the date on them was the date of manufacture. But the date on the strips specified that this date was the expiry date. These were placed for disposal. There was some schedule 3 CDs found in the pharmaceutical waste bin; this was discussed with the pharmacist at the time who said that they would be denatured instead. The bin also contained some people's personal information. The pharmacist said that he would confirm if this could be disposed of with the pharmaceutical waste.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed. The pharmacist said that uncollected prescriptions were checked monthly. He confirmed that items uncollected after three months were returned to dispensing stock where possible and the person's medication record was updated. The prescriptions were returned to the NHS electronic system or to the prescribers.

Prescriptions for people receiving their medicines in multi-compartment compliance packs were

ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy routinely contacted people to ask if they needed them. The pharmacy kept a record for each person which included any changes to their medication and kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines, and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from various authorities. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that he had undertaken some training on how the system worked, but the dispenser had not yet done the training.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring medicines was available. Separate liquid measures were marked for CD use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The dispenser said that the blood pressure monitor had been in use for around 18 months. She said that it was replaced regularly by head office. The weighing scales and the shredder were in good working order. The phone in the dispensary was not portable, but it was in an area which was not directly visible from the shop floor.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range, but the temperatures had not been checked on the day of the inspection. The maximum temperature found on the day was 16.9 degrees Celsius. The thermometer was reset and the current temperature was found to be within the recommended range. The fridge was suitable for storing medicines and was not overstocked. The area manager said that pharmacy fridge should have a data logger which monitors the temperature on an hourly basis. She arranged for one for the pharmacy and showed the pharmacist how to access the data.

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.