General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 207-215 High Street, ORPINGTON, Kent, BR6 0PS

Pharmacy reference: 1083759

Type of pharmacy: Community

Date of inspection: 10/10/2024

Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, blood pressure checks, NHS contraception service and flu vaccinations. The pharmacy supplies medicines in multi-compartment compliance packs to some people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people.

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	1.8	Good practice	The pharmacy takes appropriate action to ensure that vulnerable people receive appropriate help.
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 identifies and manages the risks associated with its services to help provide them safely. They record and review their mistakes so that they can learn and make the services safer. The pharmacy generally protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. The pharmacy takes appropriate action to ensure that vulnerable people receive appropriate help.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members' roles and responsibilities were specified in the SOPs. And they had signed to show that they had read, understood, and agreed to follow them. The dispenser said that team members could not access the dispensary if the pharmacist had not turned up in the morning. And they knew that they should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy recorded dispensing errors (a dispensing mistake that had reached a person) and undertook a root cause analysis. The RP said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. She said that she ensured that all team members had the chance to review the error before it was filed so that they could learn from it. Team members explained how they dealt with near misses, where a dispensing mistake was identified before the medicine had reached a person. Near misses were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Team members recorded near misses were and these were reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed monthly by the team. Learning points were also shared with other pharmacies in the group. And the pharmacy received a 'clinical excellence' newsletter each month from its head office.

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

The pharmacy had current professional indemnity insurance. The private prescription records were completed correctly. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions recently where the pharmacist had not completed the record when they had finished their shift and a different pharmacist was working the following day. The importance of maintaining the RP record correctly was discussed with the team during the inspection.

People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens. Team members used their own smartcards to access the NHS spine, and these were stored securely when the pharmacy was closed. The pharmacy obtained people's signatures for deliveries where possible, but there were multiple people's details on each sheet and the layout might make it harder to ensure that people's details were protected when signatures were recorded. The RP said that she would ensure that other people's personal information was protected when signatures were recorded in future.

The RP was not aware of any recent complaints. She said that the pharmacy's head office would inform the pharmacy is it received any complaints about the pharmacy. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting these people. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And they gave examples of action they had taken in response to safeguarding concerns. They had reported recent concerns to the relevant authorities and safeguarding measures have been put in place for vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. They do the right training for their roles but the pharmacy doesn't always enrol its team members on accredited courses in a timely way.

Inspector's evidence

There were two pharmacists, one trainee pharmacist, one trained dispenser (NVQ level 3 qualified) and one trainee dispenser working during the inspection. The RP mentioned that a team member who had worked at the pharmacy on a part-time basis for over three months had not been enrolled on an accredited course. She contacted the pharmacy's head office and the person had been enrolled on a suitable course the same day as the inspection. The RP explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. 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. And the pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. The trainee dispenser was aware of the restrictions on sales of medicines containing pseudoephedrine. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which may require additional care or could be misused.

The pharmacy's head office provided monthly training modules for the team which they had to complete in their own time. Training was monitored by the RP and the regional manager. And team members had recently completed some training about the Pharmacy First service. The trainee pharmacist said that he felt supported with his learning and was given half a day protected training time each week. He accessed most of his training online and had recently completed some training about conjunctivitis. He said that he was involved with clinical services at the pharmacy and had shadowed the RP during consultations. He had also undertaken some initial assessments for the Pharmacy First service while being supervised by the RP.

The pharmacists were aware of the continuing professional development requirement for professional revalidation. The RP had recently completed the face-to-face training for the flu vaccination service. And she had attended online classes about how to use an otoscope and about consultation skills. The pharmacists had completed declarations of competence and consultation skills for the services offered and had done the associated training. And they felt able to make professional decisions.

Team members explained that they had an informal huddle in the morning to prioritise and allocate tasks for the day and discuss any issues. And they also discussed these topics during shift changes. The RP attended daily conference calls with other pharmacy managers in the area and the regional manager. Team members used a messaging app to share information. And the RP said that she ensured

that information from the pharmacy's head office was shared with the team. Team members had yearly performance reviews as well an informal ongoing ones. And team members felt comfortable about discussing any issues with the pharmacist.

Targets were set for the New Medicine Service, the Pharmacy First service and flu vaccinations. Recently started to have daily conference call with the regional manager and other pharmacies in the area, due to not meeting the Pharmacy First target. The team said that they felt under pressure to meet the targets but struggled due to the population in the area being largely older people. And other local pharmacies provided the same or similar services. The RP was clear that the team would not let the targets affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access. And it was bright, clean, and tidy throughout which presented a professional image. 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. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating in the shop area for people waiting for services. The 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. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. There were several store members who could also assist. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. The pharmacy could produce large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. And an anaphylaxis kit was available in the consultation room. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The RP said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The RP said that dispensed fridge items were checked with people when handed out. The RP said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office and the RP said that she also regularly checked the MHRA website for these. She explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response. The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Items due to expire within the next six months were highlighted. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Lists of short-dated items were kept which made it easier for the pharmacy to identify these so that they could be removed from dispensing stock before they expired. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register

and destroyed with a witness, and two signatures were recorded. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs.

The pharmacist said that uncollected prescriptions were checked weekly, and people were contacted if they had not collected their items after around two weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. The pharmacy had a robust system for managing part-dispensed prescriptions and these were checked daily. It provided 'owings' notes 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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The RP said that people had assessments carried out by their GP and a medicines optimisation service to show that they needed their medicines in multi-compartment compliance packs. And she said that if she felt that a person might benefit from having their medicines in these packs, she would refer them to their GP. Prescriptions for people receiving their medicines in these packs were requested in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The RP said that people usually contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also 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.

Deliveries were made by a delivery driver. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

The phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had up-to-date reference sources were available. The blood pressure monitor, otoscope, and weighing scales appeared to be in good working order. The otoscope was cleaned after each use and disposable tips were used.

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.