General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 10 Falkland Gate, The Kingdom Centre, GLENROTHES, Fife, KY7 5NS

Pharmacy reference: 1084697

Type of pharmacy: Community

Date of inspection: 26/02/2020

Pharmacy context

This is a community pharmacy in a shopping centre in the centre of a town. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers the NHS smoking cessation service and seasonal flu vaccination.

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 team members follow written processes for all services to ensure that they provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. On the morning of the inspection the pharmacist had been unavoidably delayed so had been late to the pharmacy. She had contacted the pharmacy team. The team members did not open the pharmacy and did not undertake any activities that required a responsible pharmacist to be signed in. The pharmacist accurately recorded her time of arrival at the pharmacy. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They did this electronically and were aware that sometimes incidents were not recorded when locum pharmacists not familiar with this process were working. A trainee dispenser was aware that distractions affected her accuracy. Most errors were related to labelling or 'form'. The pharmacist reviewed incidents monthly. She had identified recently that distractions were the main cause. So, all team members were trying to avoid interrupting the dispenser labelling. They identified a person to serve on the medicines counter at given times. The team used a whiteboard to record the most recent near miss e.g. incorrect directions. Team members also recorded errors reaching patients to learn from them. There had been one a few months ago when the pharmacy had supplied the wrong strength of a controlled drug. The person had not suffered any harm and the pharmacy documented this and reported it to the NHS controlled drug accountable officer as it was required to do. The pharmacy carried out an annual audit using several parameters. It used this for learning and improving services and processes. The pharmacy manager who had started in this pharmacy around six months ago had reviewed all processes and implemented several changes. She had used the previous inspection report to help identify areas for improvement. The pharmacy was visibly tidier, and all documented processes were being followed.

The pharmacy had a complaints procedure and welcomed feedback. Over the past few months people had complimented the pharmacy team on a more efficient service. And prescription dispensing volume was increasing.

The pharmacy had an indemnity insurance certificate, expiring 31 Jan 21. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed

specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Team members did not always record full details of prescribers in methadone registers as legislation required. Sometimes they only recorded first names. But this did not pose a risk to people as they knew the prescribers.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed company documentation. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or in-training team members to provide safe services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training during the working day. Pharmacy team members make decisions appropriate to their role. Team members can share information and make suggestions to improve ways of working and to keep the pharmacy safe. They know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time pharmacy technician, four part-time dispensers (working 22.5, 21, 16 and 12 hours per week), and two part-time delivery drivers. The pharmacy displayed their certificates of qualification. One team member who worked 21 hours per week was undertaking training. The others were qualified. Typically, there were two or three members and a pharmacist working at most times. For the first and last hour of each day there was one team member with the pharmacist. Team members were able to manage the workload. They had some scope to work flexibly providing contingency for absence.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. And it provided the team member undertaking accredited training with additional time to complete coursework. The pharmacist supervised the trainee team member. And she was observed asking relevant questions. Team members had recently had development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included developing clinical skills and increasing the chronic medication service; engaging more with people requesting over-the-counter treatments; and learning more about the online prescribing service. One team member was still to have her meeting. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. The trainee team member used the sale of medicines protocol effectively and was able to fully describe a situation to the pharmacist and ask for advice. And an experienced team member used the sale of medicines protocol well to gather information and give appropriate advice. The team demonstrated awareness of repeat requests for medicines intended for short term use. And team members dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. An example was a team member suggesting how some dispensed medicines should be stored and drawers labelled. The pharmacy had adopted this. Team members described changes made since the pharmacist had started. And she sought input from the whole team. All team members were pleased with the progress and improvements they were making. The company had a whistleblowing policy that team members were aware of. The area pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. The pharmacy had white boards and notice boards displaying information for all team members to read. This included responsible pharmacist information, a regulatory and safety poster, staff rota and the current list of multi-compartment compliance packs to be assembled. Team members signed

documents as they read them. The company set targets for various parameters. Team members described using the targets to remind them to offer services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy was located at the rear of a larger store. It had shutters protecting it from unauthorised access when the rest of the store was open e.g. on Sundays. It stored general sales list (GSL) medicines out with this area. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The dispensary was very small. Team members used space well and followed processes to keep it tidy. Since the last inspection, the team had removed unnecessary items from the dispensary to maximise space. And they had improved processes to avoid baskets of dispensed medicines waiting for long periods of time to be checked. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people taking high risk medicines. the pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and its entrance was open to the shopping centre. It listed its services and had leaflets available on a variety of topics. It displayed advisory information on the current coronavirus outbreak. The pharmacy signposted people to other services such as travel vaccination. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The dispensary was small which sometimes posed challenges for the dispensing process. Recently the dispensing process had been completely reviewed and improved since the last inspection. When prescriptions were received a team member put them in order depending on how many items they were for. The pharmacy team assembled prescriptions for multiple items and deliveries first. This meant that in the afternoons, there were only smaller prescriptions for one or maybe two items left to assemble. If people presented at the pharmacy before their prescription had been dispensed it was likely to be for only one or two items so therefore reasonably quick to assemble. The team had created shelf space in the dispensary by relocating items that could be stored elsewhere. Team members used dedicated shelves to store baskets of dispensed medicines waiting to be checked. They had changed the position of baskets making them more accessible. This dispensing process was observed to work well. Team members notified the pharmacist if there were changes to people's medicines to enable her to undertake a clinical check. They initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy team scanned the bar codes on medicines to help with accuracy, but not the 2D codes used for the Falsified Medicines Directive (FMD). Team members had changed their dispensing process to accommodate scanning. They now needed to gather stock before labelling which had initially slowed the process down. But this was becoming more natural and faster now.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people phoned. They generally gave the pharmacy two days' notice. A team member checked the electronic records for CMS prescriptions to monitor compliance. Most people were compliant, but a few occasions were described when the pharmacy had contacted the GP practice about people not collecting their medicines regularly.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time the week before the first pack was due to be supplied. Team members assembled

these packs in the afternoons once the surgery prescriptions had been assembled. They kept records of changes and other interventions. They included tablet descriptions on packs and supplied patient information leaflets with the first pack of each prescription. The pharmacy kept completed multi-compartment compliance packs in labelled drawers. A team member moved the current week's packs into a separate drawer at the start of the week. This made it straightforward for the driver or another team member to select these for delivery or collection. And it enabled the pharmacy team to identify any packs that had not been supplied as expected. The pharmacy had a list of people whose packs were delivered each day on the dispensary wall. Team members referred to this to ensure all packs were delivered as expected. Team members usually initialled multicompartment compliance packs in the same way as other dispensed medicines. But some packs were observed with no 'dispensed by' signature.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. It also followed private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacist had delivered flu vaccination during the season, but this was just coming to an end. She followed written processes and was appropriately trained. There were currently no people accessing the smoking cessation service. The pharmacist had been in this pharmacy for around six months and had prioritised reviewing and improving other services and processes. She had focused on areas identified during the previous inspection. But she was now able to develop services such as smoking cessation. She had arranged for the local pharmacy champion to come to the pharmacy and deliver training, particularly for herself on the computerised patient care records as she had moved from another area.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the FMD. It had the equipment, but it was not in use. And team members had not received training. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and team members took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor which was maintained by the health board. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'methameasure' pump available for methadone use and a team member calibrated it each morning and cleaned it at the end of the day. The camera on this was broken. This had been highlighted in the previous inspection report, and team members had raised this with head office. This meant that the pharmacy could not take photographs of patients accessing this service. Team members used photographs to help with identification when they could. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. The pharmacy's phone was not cordless. It was at the front of the dispensary. So, it was difficult to have discreet phone conversations. Team members were aware of this and tried to speak quietly. Sometimes they found this challenging if people were hard of hearing.

The pharmacy stored paper records in the dispensary inaccessible to the public. And it kept prescription medication waiting to be collected in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.