General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 59 Sidney Street, CAMBRIDGE, Cambridgeshire, CB2 3HX

Pharmacy reference: 1084879

Type of pharmacy: Community

Date of inspection: 27/09/2019

Pharmacy context

The pharmacy is in the main shopping area of the city. It provides NHS and private prescription dispensing mainly to local people . The team also dispense medicines in multi-compartment compliance packs for some people. And they provide treatment and support to drug and alcohol service users. There is a flu vaccination service run by the pharmacist. There is also a travel clinic which is run by a nurse two days a week.

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

Members of the pharmacy team work to professional standards and identify and manage risks effectively. They are clear about their roles and responsibilities. The pharmacy keeps its records up to date and these show that it is providing safe services. It manages and protects information well and it tells people how their private information will be used. The team members also understand how they can help to protect the welfare of vulnerable people. The pharmacy team members sometimes log mistakes they make during the pharmacy processes. But this isn't always done so they may be missing opportunities to learn from these to avoid problems being repeated.

Inspector's evidence

The pharmacy had a set of standard operating procedures which covered the services provided. The staff said that they had read them and generally followed them. There was evidence of this . The company's process was for near misses to be recorded on a computer programme which fed back to head office and allowed analysis of the types of errors made. The pharmacist said that in the two weeks he had been there they had not recorded any near misses as accessing the computer was not convenient, and then it got forgotten. But look-alike, sound-alike medicines had been identified as an issue and amlodipine and amiloride had been separated in the dispensing drawers to try to prevent picking errors.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice.

The pharmacy sought the views of people about the service provided by the pharmacy, in an annual survey. The recent report had showed that the users of the pharmacy were a wide range of ages, and that they were generally satisfied with the services provided. The pharmacy had professional indemnity and public liability insurances in place.

The pharmacy team recorded private prescriptions and emergency supplies in a book. These records were up to date. The controlled drugs registers were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. A random check showed that the records for that medicine were correct. Fridge temperatures were recorded daily and were within the recommended range.

The pharmacy team members were observed to share NHS smart cards to access electronic prescriptions. The new dispenser was trying to get his card to work in the pharmacy, as he had moved from another region but it was proving problematic to get it done. Confidential information was kept in the dispensary and consultation room, where it could not be accessed by unauthorised people as the room was locked. The computers were password protected and screens could not be viewed from the counters.

Confidential waste was separated and disposed of using a licensed waste contractor. There was a notice about how people's information would be used.

The pharmacist had completed level 2 safeguarding training. There were local contact telephone

numbers for the safeguarding teams in the area on the wall of the dispensary. Staff reported that they had a number of vulnerable people who used the pharmacy and that referrals were sometimes made to the night shelters and surgeries regarding these people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy currently has enough qualified staff to provide safe services. The small team work well together. Training packages are provided by the company to help staff keep their skills and knowledge up to date. However, the team are not given set aside time to do this training at work and so don't always get chance to benefit from it.

Inspector's evidence

The team consisted of six staff; the locum pharmacist, two part-time dispensers who had both completed NVQ level 2 dispensing training, two medicines counter assistants and a delivery driver. One of the dispensers was about to leave but there a replacement had been appointed. It was thought that the new dispenser was already trained, but the pharmacist was not sure of this.

The company provided regular training for their staff using an e-Learning platform. The staff were not up to date with all the training modules but reported that they found them useful when they had time to do them. Training had included compulsory topics such as the General Data Protection Regulation (GDPR) and safeguarding, and these had been done. Other modules about professional subjects which were not compulsory had not been completed. No time was available during working hours to complete the training.

It was observed that the team members worked well together, and the dispensers said that they felt able to make suggestions to the pharmacist about how things could be changed to improve people's experience of using the pharmacy. All staff had regular appraisals. The pharmacist reported that the targets set by head office did not affect his professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean and provide a safe, secure and professional environment for people to receive healthcare. There is step-free access into the pharmacy. The flooring in the shop and dispensary present a potential trip-hazard and the marked ceiling tiles detract from the image presented.

Inspector's evidence

The dispensary and counter areas were clean tidy and bright. The consultation room was large enough for the services provided and was quite tidy. But there were areas of the flooring secured with tape where the edges were lifting and this presented a potential trip hazard. Staff said that they had reported it to head office, but no action had been taken to address the issue. There had been a number of leaks from the premises above the pharmacy. This had led to the ceiling tiles being marked. These had not been changed.

The dispensary was small for the volume of prescriptions dispensed. Separate areas of bench were used for dispensing and accuracy checking. Staff said that the process of scanning products for the Falsified Medicines Directive (FMD) was presenting a problem as previously baskets would just contain a prescription waiting to be labelled and so could be easily stacked. But now the products had to be selected prior to labelling and so this needed more bench space.

The consultation room provided a confidential area to provide services. There was a chaperone policy notice on the door. The room was used routinely by the pharmacist to hold private conversations. The staff had access to toilet facilities in the shop. There was hot and cold running water available at the dispensary sink.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's working practices are safe and effective and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people about where they can get other support. But the pharmacy may be missing opportunities to provide advice and support to some people who take higher-risk medicines.

Inspector's evidence

Access to the pharmacy was via the main shop and was level from the pavement. Services were advertised in the windows of the shop and around the pharmacy area.

The pharmacy used a dispensing audit trail to identify who had dispensed and checked each item. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Prescriptions where the person was waiting were put into red baskets to highlight this fact.

Some people were being supplied their medicines in multi-compartment compliance packs. Previously packs were left unsealed when waiting for stock to be delivered. The way these were dispensed had been changed to ensure that there was enough stock present so that the whole pack could be dispensed. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs.

The people being treated by the drug and alcohol team were offered use of the consultation room to take their supervised doses. There was a needle exchange service.. It was observed that the whole team had a very positive attitude to providing these services.

People taking warfarin, lithium or methotrexate, who brought their own prescriptions into the pharmacy or had their prescription on repeat, were not always asked about any recent blood tests or their current dose. If the staff noticed the items on the prescriptions when handing these out they would ask the patient. The lack of a consistent approach meant the pharmacy could not show that it was always monitoring the people in accordance with good practice. People who were receiving prescriptions for valproate in the at-risk group were not routinely counselled regarding pregnancy prevention where needed. There were educational materials such as stickers and cards available, but they were not being used.

People using the flu vaccination service were making appointments, as it was the start of the season. There was a lot of interest in the service, but the staff were waiting for the main stock of vaccines to arrive. There were patient group directions in place for this activity, for both the NHS and private services.

The pharmacy got its medicines from licensed wholesalers, stored them in dispensary drawers and on shelves in a tidy way. There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. The pharmacy was scanning medicines in compliance with the FMD although the pharmacist was not sure that the information was being sent

back to the MHRA. There was another computer in the consultation room, which could have been used for dispensing the multi-compartment compliance packs but as it did not have an FMD scanner it was not being used. Patient-returned controlled drugs were listed in a book and destroyed as soon as possible after receipt.

Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment had been safety tested and had passed.

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.