General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, Unit 3, The Bridges, Walworth Way, SUNDERLAND, SR1 3LB

Pharmacy reference: 1084970

Type of pharmacy: Community

Date of inspection: 03/01/2020

Pharmacy context

This pharmacy is located at the rear of the Superdrug store in the town centre shopping complex. The pharmacy dispenses NHS and private prescriptions. And offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs. These help people remember to take their medicines. It provides blood pressure checks and a flu vaccination service. The pharmacy closes on Sundays when the main store remains open. And also, the main store remains open later one evening when the pharmacy closes at 5.30pm.

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 has written procedures that the team members follow. They have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. But the detail they record is sometimes limited. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring. The pharmacy keeps all the records as required by law, in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the prescription process, influenza service and controlled drugs (CDs). These were subject to regular review. And the company had reviewed the majority in November 2019. The team members had signed the SOPs online once read and they had completed the required tests. The team could advise of their roles and what tasks they could do. There were also several other corporate checks undertaken daily and weekly to manage the running of the pharmacy. And the pharmacy had audits on tasks.

The pharmacy had a main raised dispensary with one computer terminal. And a lower dispensary area which also had a computer terminal. The pharmacist tended to generate most of the labels. And the dispensary team obtained the stock and labelled the items. Then the pharmacist checked these. There was a section of bench which the team used for the compliance pack preparation. The team utilised the space well. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for people waiting, white for call backs and clear for the repeat prescriptions. This distinguished people's prescriptions by degree of urgency and this helped plan workload. The team took completed prescriptions in the baskets to the pharmacist's checking area.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these directly on to the system, Pharma pod. The dispensary team members could all use Pharma Pod. And demonstrated how to log in. And they entered their own near miss onto the system once they became aware of it. There were few near misses recorded, with one or two each month. The team explained that the number had decreased since the introduction of the scanning of packs as part of the implementation for the Falsified Medicines Directive (FMD). The pharmacist showed the monthly patient safety report which he printed off and kept in the clinical governance folder. Examples included wrong drug form on the label and wrong drug selected, with Evohaler instead of Accuhaler. There were few comments recorded and little detail about the near miss or any reasons for it. The team members were aware of the Look-Alike Sound-Alike (LASA) drugs and had discussed these. They tended not to use shelf alerts to highlight these to raise awareness as potential picking errors but thought they may put some in place. The pharmacy had a notice displayed in the pharmacy which explained the complaints process. The team members reported any incidents or complaints to the pharmacist. And they recorded these on to the Pharma Pod system and the pharmacy fully investigated complaints. The

pharmacy had current indemnity insurance with an expiry date of 31 January 2020.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. The pharmacist signed out for half an hour each day for a lunch break. The team knew what tasks they could and could not undertake during this time. The team switched off the dispensary lights during this time to alert people that the dispensary was closed. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy team checked CD stock against the balance in the register after each dispensing. This helped to spot errors such as missed entries. The pharmacy team completed the headings as required. And the pharmacy maintained running balances. The register indicated weekly stocks audits had been undertaken. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy had recently started to keep its private prescriptions electronically. And the pharmacist was still maintaining a paper record for the present time. There were several entries each month with supplies made through the company's online service. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information on the confidential data kept and how it complied with legislation. It had NHS leaflets explaining the requirements for data storage and how data mattered. People could take these leaflets away. The team had an Information Governance policy with a Data Privacy Policy which the company updated annually. The team completed training on this annually. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy kept patient sensitive information securely. The pharmacy team stored confidential waste in separate bags for offsite shredding.

The pharmacy had a policy for the protection of vulnerable adults and children. And the team had read this and undertaken a quiz at the end to ensure there understanding. Safeguarding information including contact numbers for local safeguarding were available for the team. The pharmacist had undertaken level 2 CPPE training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team. And the pharmacist and team members suitably provide the pharmacy's services. The pharmacy encourages and supports the pharmacy team to learn. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. They feel comfortable to discuss their development needs with the pharmacist and raise any concerns if necessary.

Inspector's evidence

There was one pharmacist, a dispenser and a pharmacy student working in the pharmacy. In addition, there were two medicine counter assistants (MCAs), both in training, and another dispenser. The dispenser present worked 40 hours a week but was flexible and worked extra if required. The pharmacy student worked on Saturdays and also helped out when other members of the team were off. The other dispensing assistant worked eight hours on one day each week. Both MCAs were undertaken training on a formal course. One worked 22 hours a week. And the other eight hours a week, split over two days. Various different locums generally covered most Saturdays, with the pharmacist manager undertaking some. The total staff hours for the pharmacy were 131 hours a week. The pharmacy had reviewed the staff hours last year and the company had increased these due to an increase in prescriptions. The pharmacist advised that the prescription figures had increased since the last review and that another review of the staffing hours was due.

Certificates and qualifications were available for the team. And the pharmacy displayed rotas for each staff member. The team members had training records on the computer system, the Edge. And they undertook ongoing training through this system. The training included reading revised SOPs and training on various health topics and products. The team completed quizzes after reading the topics to check their understanding. The pharmacy gave the team time for training during quieter times. Recent training had included Day and Night Nurse and sales of medicines. The head office sent the team emails to tell them of training they required to undertake. And the manager checked on the system to ensure everyone was on track. And completed the training within the specified completion dates.

The team received performance reviews which gave them the chance to receive feedback and discuss development needs. Their reviews were taking place the following week. One of the dispensers expressed an interest in undertaking the technician's course. And was hoping that she would be considered for this especially due to the prescription numbers increasing. The team followed the sales of medicines protocol when making over-the-counter (OTC) recommendations and referred to the pharmacist when necessary.

The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. The pharmacy counter was busy with inquires. And the team spent a lot of time assisting people. And often took them to sections in the store when they asked about health-related items. The pharmacist advised that at times this was challenging with the small team. And the interruptions in the dispensing workflow.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist or the area manager. There was a whistleblowing policy and a confidential helpline available

so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The pharmacy team had targets for services such as MURs. These were achievable and done when they met the patient's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure and of a suitable size for the services the pharmacy provides. People can have private conversations with the team in the consultation room.

Inspector's evidence

The pharmacy was fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The team were tidying and cleaning following the busy time over the holiday period. Some of the drawer units in the dispensary were sticking and did not close properly. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The team generally undertook cleaning tasks on a Saturday. And had a cleaning rota to ensure they maintained this. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team promoted for use. The pharmacy team members kept the consultation room locked when not in use. This ensured any unauthorised access as they kept the sharps bin in the consultation room. There was no confidential information left in the room. There was a gate at the end of the medicines counter. And a further gate at the entrance to the dispensary. The main part of the dispensary was raised, and the pharmacist clearly observed people at the counter. The team members attended to people at the counter. When the pharmacy closed, and the store remained open people could not access the pharmacy due to the gates. And the team members pulled down shutters and locked the sections with pharmacy medicines to prevent unauthorised sales. The team placed a notice advising people the pharmacy was closed and highlighted the restrictions for sales.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. It displays information about health-related topics. And it provides its services safely and effectively. The pharmacy team members take steps to identify people taking some high-risk medicines. And they provide people with advice. The pharmacy gets its medicines from reputable suppliers. And it mostly stores and manages its medicines appropriately. It takes the right action if it receives any alerts that a medicine is no longer safe to use. The pharmacy members dispense medicines into multi-compartment compliance packs to help people remember to take their medicines correctly. But they generally don't provide written information leaflets to these to people with information about their medicines.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. The doors of the main store were directly open to the main concourse of the shopping centre during opening hours. And the walkways from the main entrance to the pharmacy were clear. The pharmacy displayed its opening hours in the front window and at the medicines counter. At the medicines counter it displayed information about the services available. It had a range of health-related leaflets and information near the medicines counter. Leaflets included 'stop smoking advice' and 'blood pressure checks'. The pharmacy displayed the clinical commissioning group's information on how to 'look after yourself, a guide to self-care'. There was some customer seating. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The pharmacy medicines were kept behind the counter. And the team assisted people with advice on these items.

The pharmacy provided Medicine Use Reviews (MUR)and the New Medicines service (NMS). It had completed the required number of MURs by the end of the year. The pharmacist advised that these were good to do, to advise people on their medicines and to build up a relationship. He advised that many people then came back to ask for more information which benefitted them. During the inspection several people asked to speak to the pharmacist for advice. The pharmacist advised that the NMS had picked up lately. And the follow ups were undertaken by phone calls. The team kept a book to ensure that the pharmacy contacted people complete the process. The pharmacist had undertaken around 300 flu vaccinations. The majority had been people walking in for the service. The pharmacist had also been to a school and college and provided the service. A few people had made appointments for the service.

The pharmacist had completed training for a new Patient Group Direction (PGD) for throat infections which involved taking a swab from people. And then being able to provide penicillin if appropriate. He had not undertaken through the service to date. The service was being promoted through social media and he advised some people had expressed an interest. The pharmacy provided blood pressure checks and a smoking cessation service. The pharmacy provided Emergency Hormonal Contraception (EHC) with a charge but not through the PGD. The pharmacist was waiting for some paperwork to be completed in order to provide this service. The pharmacy signposted people to other pharmacies if they did not wish to pay for the service and wanted it under the PGD. The pharmacy offered the Community Pharmacy Consultation Service (CPCS). The CPCS connected patients who have a minor illness or need

an urgent supply of a medicine with a community pharmacy as their first port of call. The referrals came from NHS 111. The pharmacy had undertaken a few on Saturdays.

The pharmacy supplied medicines to around 62 people in multi-compartment compliance packs to help them take their medicines. The doctors generally referred people to the pharmacy to have their medicines in compliance packs. The pharmacist generally prepared the labels. And the dispensary members obtained the stock and filled the packs. The pharmacist then checked the packs. Some people received four weeks of packs at one time and other weekly. The pharmacy bagged the four weeks together. The pharmacy used trackers to monitor the prescriptions for the compliance packs. And each patient had a profile sheet with a communications record. The communications record clearly showed any requested changes documented. The packs did not include descriptions of medicines. The pharmacist advised there was a new SOP and he was reviewing the process. The pharmacist advised that the pharmacy did not provide Patient information leaflets (PILs) with each cycle as required by legislation. And this was something he had been unclear on.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team kept dispensed items ready for hand-out on a designated shelf in the fridge. And checked these again prior to hand-out. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These ensured patients received additional counselling. The pharmacists sometimes wrote detailed explanations on post-it notes to ensure that the pharmacy provided the appropriate information to people. This included some information on the dose of ibuprofen to ensure the patient did not take the maximum amount. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that the pharmacy required to add some medication to complete the supply. The team checked through the uncollected items each month. This prevented supplies being made when the prescription was no longer valid.

When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. And had a notice displayed in the dispensary as a reminder to the team. They explained the information they provided to the 'patients in the at-risk' group. The pharmacy generally stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. But there were some amber bottles with insufficient labelling details such as no batch number or expiry date. These were items which had been removed for the compliance packs following changes. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings in the daily task book, and they checked these to ensure the refrigerator remained within the required temperature range.

The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members placed stickers on short-dated items. And they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. The pharmacy obtained medicines from reputable sources. The pharmacy was ready for the requirements for the

Falsified Medicines Directive (FMD). The pharmacy had SOPs for the process. And the team had received training. The pharmacy was scanning packs at the dispensing point but was not scanning out all items at the point of supply. The team used appropriate medicinal waste bins for patient returned medication.

The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. The pharmacist put these on the monthly patient safety review for information and to raise awareness.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people’s privacy.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It also had a range of equipment for counting loose tablets and capsules. The team members cleaned triangles after use. The team members had access to disposable gloves and alcohol hand washing gel. The blood pressure machine appeared in good working order and the pharmacy replaced it when required.

The pharmacy stored medication waiting collection in drawers where no confidential details could be observed by people. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private.
The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations.

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.