General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, G35 Main Deck, Princes Quay Shopping Centre, HULL, North Humberside, HU1 2PQ

Pharmacy reference: 1106905

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

This community pharmacy is in a Superdrug store within a shopping centre in Hull city centre. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartmental compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the flu vaccination service.

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	1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services.
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 identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members record and discuss errors that happen whilst dispensing. And they respond appropriately. As they make changes to the way they work to reduce the risk of similar errors happening. The pharmacy has appropriate arrangements to protect people's private information. And it keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy kept the SOPs electronically and printed them off for reference. The pharmacy team members read the SOPs and completed a test to show their understanding. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. And the team members recorded their own mistakes. A sample of the near miss error records looked at found that the team recorded details of the error to spot patterns. And the cause of the error. But the team did not always record the actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team used the same system to record other incidents such as data breaches. The team had used the system to report an incident when a person's prescription was found inside a pharmacy information leaflet on the pharmacy counter. The person had received their medicine and even after reflection the team could not understand how the prescription had ended up in the leaflet. The pharmacy undertook a monthly patient safety review. A recent review highlighted the issue that high-volume dispensing periods often caused near miss errors. So, the team was reminded of this and made aware of common errors. The pharmacy also completed an annual patient safety report. The latest report stated that the team discussed the importance of managing and avoiding disruptions until the dispenser had completed the dispensing of prescriptions. The report also raised the issue of picking the wrong formulation or strength of medicines that looked and sounded alike (LASA) . The team placed red stickers on shelves holding LASA products to prompt a check of what was selected. The team had also rearranged the different strengths of some products. To reduce errors involving the wrong quantity the team wrote the quantity remaining in a pack on a sticker attached to the container. So, the team was aware the pack was not full.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The pharmacy had seen an increase in prescriptions presented by people who had previously used a local pharmacy that had recently closed. This pharmacy had provided a text messaging service informing people when their medicines were ready to collect. Several people

complained to the team that the pharmacy did not provide this service. So, the team members took the telephone numbers from people and telephoned them to tell them when their medicines were ready to collect.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy did not display a privacy notice in line with the requirements of the GDPR. The pharmacy had a folder containing up-to-date information governance documents. And confidentiality agreements signed by the team. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team, and the team members work well together. The pharmacy team members receive feedback about their performance and discuss how they can make improvements. They complete some ongoing learning to keep their skills up to date. But there are not always opportunities for team members to progress with further qualification training. And not all the team members have the qualifications and skills to work in the dispensary. And this means the pharmacist adapts the way they work on a regular basis.

Inspector's evidence

Locum pharmacists covered the opening hours. The pharmacy team consisted of one part-time qualified dispenser and a part-time medicines counter assistant (MCA). The dispenser delivered medicines to some people. The dispenser provided the service a few days a week and there was no dispenser support during this time. The previous GPhC inspection found the MCA was working in the dispensary. After the inspection the company told the MCA to only work on the pharmacy counter. Since the last inspection the number of prescriptions had increased. So, the qualified dispenser had increased their hours. But some parts of the day remained without dispenser support. The MCA expressed interest in training to be a dispenser but had not been given the opportunity. The area manager and cluster manager regularly contacted the team to offer support and guidance. The dispenser dialled in to the weekly teleconference, so she could keep up to date with company information and initiatives. And shared the details from the call with the MCA and regular locum pharmacists.

The pharmacy only had dispenser support from 9.30am to 1.30 pm each week day. When working alone the pharmacist informed people presenting prescriptions that they would take longer to dispense. The pharmacist took a mental break between dispensing and checking their own work. This helped to spot any errors. The pharmacist showed dispensed items such as inhalers and insulin to the person at the point of handing over the medicine. So, an extra check could take place. Most dispensing took place when one the dispenser was on duty. When a prescription arrived at the pharmacy when the dispenser was doing the deliveries and it was not immediately required the pharmacist dispensed the prescription. And then asked the dispenser to check it when they returned before the pharmacist undertook a final check.

The pharmacy provided extra training through e-learning modules. The team members were informed via email of new training modules. Recent modules included learning on the product Nytol. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The pharmacist worked with the dispenser to set up the new community pharmacist consultation service (CSCS). The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately. The pharmacy keeps records of prescription requests and deliveries it makes to people's home. So, the team can efficiently deal with any queries.

Inspector's evidence

People accessed the pharmacy via the store entrance. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team had access to the internet to direct people to other healthcare services. The team wore name badges detailing their role. The pharmacy had up-to-date patient group directions (PGDs) to provide the flu vaccination service. These provided the pharmacist with the legal authority to administer the vaccine. The team had continued to receive requests from people for the flu vaccination service after the pharmacist manager who provided the service no longer worked at the pharmacy. One of the regular locum pharmacists was asked by the company to train to provide the service which the pharmacist agreed to. So, the pharmacy continued to provide the service. The pharmacy had adrenaline injections available in case someone had an anaphylactic reaction.

The pharmacy provided multi-compartmental compliance packs to help seven people take their medicines. People received monthly or weekly supplies depending on their needs. The qualified dispenser managed the service. To manage the workload the dispenser usually ordered prescriptions one week before dispensing. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The dispenser checked received prescriptions against the list. And queried any changes with the GP team. The dispenser picked the medicine for the packs before dispensing. And the pharmacist checked the medicines to spot any errors before the medicine was removed from the packaging. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. The pharmacy provided a repeat prescription ordering service. The team filed the repeat prescription slips in date order according to when the next request was due. The team informed the person when they collected their medicine when the next supply would be ready to collect. And asked the person what medicines they wanted for the next supply. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team placed the order in a dedicated basket where it remained until the prescription arrived. The team placed outstanding requests in a separate basket, so they knew which ones to chase up. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had a PPP poster reminding the team of the criteria. And it had the PPP pack to provide people with information when required. The team kept some PPP leaflets on the pharmacy counter to hand out to people. The

team asked people prescribed high-risk medicines such as warfarin for information such as blood tests and dose. And recorded this information on the electronic patient record (PMR).

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. And they used this as a prompt to check what they had picked. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. This included the pharmacy team contacting the person to remind them to collect their prescription. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The dispenser provided the delivery service. So, she could help people with their queries at the point of handing over their medicine. Or ask the pharmacist for the answer and contact the person when she returned to the pharmacy. The dispenser spent time with a person in their home explaining how and when to take one of their medicines that had specific dose instructions. The dispenser also collected prescriptions from the GP surgeries. So, she could check for missing prescriptions or items before leaving the surgery. The dispenser usually rang people before delivering their medicines to confirm they would be available.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a coloured sticker to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team were scanning FMD compliant products. The team wrote FMD on a sticker attached to the prescription to show the product had been scanned. The pharmacy had FMD procedures and guidance for the team to refer to. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access.

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.