General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, Unit E1, St. Nicholas Centre, Aberdeen, Aberdeenshire, AB10 1HW

Pharmacy reference: 9010198

Type of pharmacy: Community

Date of inspection: 10/04/2019

Pharmacy context

This is a shopping centre pharmacy in a city centre. The pharmacy is located at the rear of a larger store. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental medicine devices. Other services that the pharmacy offers include the chronic medication service (CMS), minor ailments service (eMAS), travel vaccination, and flu vaccination during the flu season.

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

The pharmacy team members follow processes for all services to ensure that they are safe. They record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. The pharmacy team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) reviewed every two years were in place and followed for all activities and tasks. These were available online with all staff members having password protected access, clarifying which they had read and were competent in. There were paper copies available in the pharmacy for reference, and a document confirming which SOP different staff roles should be competent in. There had been an SOP issued recently covering the requirements of the falsified medicines directive (FMD) and all staff had read it. The pharmacist had highlighted pertinent points, although the system was not live in pharmacy.

A pharmacy risk assessment been undertaken within the past year and all staff members had signed the risk assessment training register, including a nurse who delivered services.

A Superdrug pharmacy information pack, and a local NHS locum pack were available to ensure locum pharmacists were familiar with processes.

Dispensing, a high-risk activity, was observed to follow a logical and methodical process. There were coloured baskets in use to segregate each patient's medication and enable priority to be given to urgently required items. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels. Business continuity planning was in place to address maintenance issues or disruption to services. This was stored in the clinical governance file.

Near miss logs were kept and error reporting was in place. These were recorded electronically, and this was observed. There were very few incidents, partly due to scanning of dispensed medicines which increased accuracy. This pharmacy was piloting scanning. Some problems had been encountered, so it had not yet been rolled out to all other stores. Head office and the software provider were aware of the issues.

A recent error had involved an incorrect dose of methadone being supplied for supervised consumption. The pharmacist realised after consumption. It was a larger dose than intended. The pharmacist contacted the community psychiatric nurse, and the prescribing doctor. The person did not suffer any ill effects, so no action was required. Reporting was observed including to the Superdrug area manager and the NHS accountable officer. On reflection, this was caused by mistaken identity, as staff members knew patients well.
All near misses, errors and controlled drug discrepancies were recorded, and a monthly report was received from head office.
These were reviewed and discussed with all team members, and changes were made, as the team felt appropriate. A recent report highlighted that interruptions were contributing to incidents. This was

being managed by acknowledging people presenting at the pharmacy, but not stopping tasks to serve them. If people were wanting to pay for non-pharmacy items they were politely directed to another cashpoint on the premises. The pharmacy kept running balances of diazepam tablets, following incidents previously involving these.

Other audits and checklists were undertaken to ensure all processes were being followed. Recently 100 per cent compliance was achieved.

There was a complaints procedure in place. An annual customer survey was undertaken, looking at various criteria, such as cleanliness, welcome, and healthy living advice. All responses had been positive, with a few comments about waiting area which could be improved. The area was shared with a nurse providing vaccinations, so was sometimes busy.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

Indemnity insurance certificate was in place, expiring Jan 2020.

The following records were maintained in compliance with relevant legislation: the responsible pharmacist notice was displayed; responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs registers, with running balances maintained and regularly audited and records of patient returned controlled drugs. The patient medication records (PMR) were backed up. And alterations to records were attributable, by pharmacists' initials.

Staff members were aware of the need for confidentiality. Data protection training had been undertaken by all. There was an information governance policy and documents. These had been updated and issued the previous month and were read and signed by team members. No person identifiable information was visible to the public. Confidential waste was segregated for secure shredded.

There was high awareness of safeguarding, and staff members knew how to raise concerns. The pharmacists were PVG registered and the scheme membership certificates were observed. There was a chaperone policy in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has qualified and experienced staff to safely provide its services. Although, sometimes there are not enough staff members for all services, so people are advised to come back later or go to another pharmacy. The pharmacy 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. Team members know how to raise a concern if they have one. Their judgement, and patient safety are not affected by targets.

Inspector's evidence

Staff numbers working in the pharmacy: two pharmacists, one working four days, and the other working two days, one full-time dispensing assistant, one medicines counter assistant working half day Saturday, one pharmacy student who covered holidays. And one delivery driver working four hours per week. The pharmacist worked two hours alone each day, and half day Saturday. This meant that some services could not be offered during that time, and all dispensing was self-checked. People requiring services such as emergency hormonal contraception, purchase of sildenafil, and antibiotics for urinary tract infections were asked to come back later in the day or signposted to another pharmacy which was close.

The inspector observed a queue of people developing at the medicines counter during the dispenser's lunchbreak, while the pharmacist was supervising methadone consumption. It was difficult for her to see the counter from this area, so she was unaware of people waiting. Although she was not be able to address it while undertaking supervision.

Team members were observed to manage the workload, and the skill mix was suitable although it appeared challenging. There were often people waiting at the medicines counter. It was difficult to cover Saturday pharmacist absence with locum pharmacists due to the lone working. There was a rota on the dispensary wall, so all team members knew who was working when.

Certificates of qualification were displayed. Training was undertaken regularly, and records kept. All team members had their own password protected areas recording training undertaken and SOPs read. Staff development meetings were held annually for most team members, and twice yearly for pharmacists. Meeting targets formed part of this, particularly for pharmacists. Development plans recorded individual learning needs which were identified and addressed.

The various individuals were observed going about their tasks in a systematic and professional manner. They were observed to ask appropriate questions when selling medicines over-the-counter. Team members were aware of items that may be abused, and frequent purchases made by people.

Openness, honesty and learning was demonstrated by their approach to incident recording and review. Team members described understanding the importance of reporting mistakes. They were comfortable owning up to mistakes.

Monthly newsletters from the pharmacy superintendent, and weekly communications from head office were received, printed, read by all team members and filed. A recent newsletter had included information about medicines being abused, controlled drug reporting, near miss incident reporting and

information about the valproate pregnancy prevention. Weekly communications covered a variety of topics such as performance against target, training and stock issues.

There was a whistleblowing policy in place and team members knew who to speak to if they had concerns. Requests from the pharmacy for more staff hours had not resulted in any additional hours. The members knew to contact the NHS accountable officer if there were any controlled drug concerns. As noted above this had been done when there had been a dispensing error involved in a controlled drug.

Targets were set for various parameters. Prescription collection service was promoted to people who would benefit. No services were offered unless the pharmacist believed there was a clear benefit to patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. The pharmacy team members use a private room or area for some conversations with people. People cannot overhear private conversations. Team members cannot see people entering the private area as there is poor visibility and no mirror. They rely on people ringing a bell. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy was small and was located at the rear of a larger store. There was a sink in the dispensary with hot and cold running water, soap, and clean hand towels. People were not able to see activities being undertaken in the dispensary.

There was a consultation room with a desk, chairs, sink and computer. This was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access.
There was a separate area for specialist services such as substance misuse supervision. People accessed this and rang a bell. The pharmacist supervised through a hatch between this area and dispensary. Due to the shape and layout of the pharmacy, the pharmacist was unable to see the medicines counter from the supervision hatch in the dispensary. People accessing this area could not be seen from the medicines counter or dispensary. There was no clear line of vision, and no mirror or camera. There was reliance on people ringing the bell after entering the area.

The premises were observed to be clean, hygienic and well maintained. The pharmacy was usually cleaned by pharmacy staff. Sometimes the pharmacist asked the store cleaner to wash the floor. He took care to ensure that no person identifiable information was visible, and a member of the pharmacy team was always present.

Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other people.
Shutters protected the pharmacy area when the pharmacy was closed and the store was open. This was only on Thursday evenings.

Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has strategies in place to ensure all people can access its services. The pharmacy team provides safe services. But some medicines that are taken and supervised in the pharmacy do not have labels on them. This is a legal requirement. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

There was good physical access by means of a flat entrance and an automatic door. Services provided were displayed. There were strategies in place to assist people accessing pharmacy services e.g. a hearing loop in working order was available, large print labels were supplied for people with impaired vision, tablets were removed from packaging into bottles with plain tops for people with dexterity difficulties and tablets were halved for people who took half a tablet at a time. The pharmacy signposted to other services e.g. when the pharmacist was working alone. Leaflets on a range of topics were available.

All staff members wore badges showing their name and role.
Dispensing work flow observed to be smooth and efficient. Items to be dispensed were collected and placed in individual baskets per patient with prescriptions. The pharmacist undertook much of the labelling which enabled her to clinically check. The dispenser attached labels to medicines, scanning barcodes on packaging and checking expiry dates. Scanning packaging helped with accuracy. Pharmacist information forms were used to share information between the pharmacist and dispenser, and the pharmacist undertook the final accuracy check. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. Additionally, initials of personnel involved at all stages of dispensing and supply were captured on prescriptions.

Owings were usually assembled later the same day or the following day. There was a documented owings system in place.

There was a delivery service and signatures were obtained on receipt. Few deliveries were undertaken due to the limited hours that the driver worked (four hours per week). Labels were attached to the delivery sheet and people signed on the reverse of this, so individuals' privacy was managed. Medicines were not placed through letterboxes. The delivery driver collected prescriptions from 16 GP practices in the city three times per week. On these days the practices were contacted to check if there were prescriptions to collect. This was to increase efficiency as time was limited.

Multi-compartmental co0mpliance packs were managed on a four-weekly cycle with four assembled at a time. This activity was always undertaken during the week, and not on Saturdays when the pharmacist was working alone. The pharmacist always undertook the clinical and accuracy check immediately after assembly took place. The pharmacist sealed devices that had a lot of tablets in them, to enable her to visually check each one. Patient information leaflets (PILs) were supplied with the first pack of each prescription. Tablet descriptions were included on packaging, and the person's name was written on the spine of the device to help identification. At the end of each week, the following week's packs were placed in bags ready for supply. This gave a visual check of any outstanding supplies for the

week. There was a white board used in the dispensary listing deliveries and people who collected their medicines. Signatures were retained as evidence of supply. Robust records were maintained including any relevant clinical information, such as clozapine prescribed by a hospital, and changes to medication.

Methadone instalments were poured by a dispenser and checked by a pharmacist as people presented in the pharmacy. Supervised instalments were poured straight into cups which were not labelled. This was due to an issue with the labelling system, requiring medicines to be scanned as they were supplied. The scanning was undertaken in bulk at the end of the day. 'Takeaway' instalments were dispensed daily for the following day, by the pharmacist. These were stored overnight in a controlled drug (CD) cabinet then checked the following day. Pharmacist was observed to engage each person receiving methadone in use for conversation, which ensured that they were well enough to receive their medication. People shared information with the pharmacist that suggested a good relationship had been developed. People were well known to the pharmacist and team members, so identification was not routinely asked for. This, and a lack of label on cups may have contributed to the error noted above.

Clinical checks were undertaken by a pharmacist and people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place although there were currently no relevant people receiving valproate. Examples were described of checking that appropriate monitoring was in place for people receiving warfarin and methotrexate. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell. Team members were aware of information to be supplied and the written information was available at the medicines counter.

NHS services followed the service specifications and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment. These were current, and the pharmacists had been trained and signed them.

There were around 20 people receiving medicines on chronic medication service (CMS) prescriptions. These were dispensed when people came in to the pharmacy or phoned. The pharmacist checked the computer weekly to monitor compliance. She described a few examples of discussing this with patients and supporting them to synchronise their medicines. She had identified a few pharmaceutical care issues when registering people e.g. reminding them when to take medicine in relation to food.

Staff members were empowered to deliver the minor ailments service (eMAS) within their competence. The inspector observed a person requesting sildenafil being signposted elsewhere when the pharmacist was working alone. She was not able to spend time in the consultation room leaving the pharmacy unattended. Travel vaccinations were delivered by a nurse with very little pharmacy involvement. Pharmacists delivered the smoking cessation service, and there was currently one person receiving nicotine replacement therapy.

Invoices were observed from licensed suppliers. The pharmacy did not comply with the requirements of the Falsified Medicines Directive (FMD).

Records of date checking, and stock rotation were observed, and items inspected were found to be in date. Medicines were stored in original packaging on shelves and in drawers. Items requiring cold

storage were stored in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. This was done twice daily, and a data logger was reset monthly and replaced annually. Controlled drugs (CDs) were stored in a CD cabinet. Space was well used to segregate stock, dispensed items and obsolete items. There was very little stock. Pharmacy (P) medicines were protected from self-selection. Sale of P medicines was as per sale of medicines protocol.

MHRA recalls and alerts were actioned on receipt and records kept. People were contacted following 'patient level' recalls. Items received damaged or faulty were returned 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

Texts available in the pharmacy included current editions of the British National Formulary (BNF) and BNF for Children. There was internet access allowing online resources to be used.

A carbon monoxide monitor maintained by the health board, was available for people accessing the smoking cessation service.

Crown stamped measures were kept by the sink in the dispensary, and separate marked ones were used for methadone. Clean tablet and capsule counters were also kept in the dispensary, and were washed after use.

Paper records were stored in the dispensary. Computers were never left unattended and were password protected. Screens were not visible to the public. Care was taken to ensure phone conversations could not be overheard.

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.