General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, The Harlequin Shopping Centre, Superdrug Unit 153, Watford, Hertfordshire, WD17 2TN

Pharmacy reference: 9011666

Type of pharmacy: Community

Date of inspection: 02/02/2022

Pharmacy context

The pharmacy is in a shopping centre in Watford. It dispenses NHS prescriptions and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription delivery, repeat prescription ordering, supervised consumption and vaccinations for seasonal flu. Nurse led clinics include: travel health, occupational health, aesthetics and phlebotomy. The pharmacy opened during September 2021. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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's working practices are generally safe and effective. It has appropriate written procedures which are up-to-date and tell team members how to work safely. Members of the team record their mistakes so they can learn from them and help prevent the same mistakes happening again. They have new ways of working to help protect people against COVID-19 infection. The pharmacy mostly keeps satisfactory records it needs to by law so it can show it is providing safe services. And it encourages people to give feedback it can act on to improve its services. Members of the pharmacy team keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) printed a monthly report. Members of the pharmacy team recorded mistakes they had made online and discussed them to learn from them and reduce the chances of them happening again. The RP explained that medicines involved in incidents, or similar in some way, such as amlodipine and amitriptyline, were usually separated from each other in the dispensary. The pharmacy had a complaints procedure and people were signposted to it online to deal with any complaints. There was a practice leaflet on display and people could give feedback face to face, or via Google and there were details of how to leave feedback on the till receipts.

Members of the pharmacy team responsible for making up people’s prescriptions used baskets to separate each person’s medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking medicines. Assembled prescriptions were not handed out until they were checked by the RP. Members of the team showed interactions between prescribed medicines to the RP. Interventions were recorded online and on the patient medication record (PMR). Patients were alerted to prescription messages from their doctor such as ‘blood test due’.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were reviewed centrally at the pharmacy’s head office. The pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. Members of the pharmacy team knew what they could and couldn’t do, what they were responsible for and when they might seek help. Their roles and responsibilities were described within the SOPs. A team member explained that they wouldn’t hand out prescriptions or sell medicines if a pharmacist wasn’t present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. And a written occupational COVID-19 risk assessment for each team member had been completed. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They were self-testing for COVID-19 regularly. They had personal protective

equipment (PPE) and screens had been fitted at the medicines counter to help reduce the risks of infection with the virus. And they washed their hands and used hand sanitising gel regularly. The pharmacy completed an annual risk assessment which included delivery service, SOPs, service staff and hygiene rota. The pharmacy completed a weekly self-audit to monitor systems and processes such as business continuity plan, legality of the pharmacy and stock management.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the RP was at the moment and kept a record to show which pharmacist was the RP and when. The pharmacy had controlled drug (CD) registers and checked the level of stock regularly. A random check of the actual stock of one CD matched the quantity recorded in the CD register. The methadone registers were mostly complete. The pharmacy kept records for the supplies of the unlicensed medicinal products it made and recorded the emergency supplies it made and the private prescriptions it supplied electronically. And these were generally in order.

The pharmacy team kept people's private information safe and made sure it couldn’t be seen by other people and was disposed of securely. A privacy notice telling people how their personal information was gathered, used and shared by the pharmacy was not seen on display. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members who work well together to provide safe services and manage the workload. People who work in the pharmacy do ongoing training to keep their knowledge and skills up to date. Team members can make suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist and two part-time regular locum pharmacists, a full-time dispensing assistant and three part-time medicines counter assistants. The pharmacy's team members were enrolled on or had completed accredited training in line with their roles.

Members of the pharmacy team worked well together serving people and processing prescriptions safely. The RP was responsible for managing the pharmacy team, supervising the supply of medicines and advice given by the pharmacy team members. They had completed training in a range of topics in line with the pharmacy quality scheme (PQS). These included risk assessments, dealing with 'look-alike, sound-alike' (LASA) medicines, inhaler technique, infection control and antimicrobial stewardship. Compliance training such as health and safety, SOPs and general data protection regulation (GDPR) were provided through 'Edge' online training platform. Team members had appraisals with line managers to monitor performance and identify training needs.

The RP organised regular meetings to brief the team on COVID and other updates, discuss near misses and share learnings. The updates included information on services, targets and key announcements and were shared via the dispensary notice board and a WhatsApp group. Team members were able to provide feedback at meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's new premises are clean, bright, secure and suitable for the provision of healthcare. It protects the privacy of people using its services and prevents unauthorised access to its premises keeping its medicines and people's information safe. The pharmacy has put measures in place to help protect people from COVID-19 infection.

Inspector's evidence

The registered pharmacy premises were spacious, bright and secure. And steps were taken to make sure the pharmacy and its team didn’t get too hot. The pharmacy had a medicines counter, and a large dispensary which had extensive workspace and storage. The pharmacy had a consultation room so people could have a private conversation with a team member. The consultation room was lockable and equipment could be secured in cabinets. Cloakroom facilities were nearby in the storeroom. Members of the pharmacy team maintained records for keeping the pharmacy’s premises clean and tidy. To help protect against infection, screens and barriers had been fitted and team members had personal protective equipment (PPE) and hand sanitiser to apply.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy's working practices are generally safe and effective. It sources, stores and manages its medicines to make sure the medicines it supplies are fit for purpose. Members of the pharmacy team take the right action if any medicines or devices need to be returned to the suppliers. And they make sure people have all the information they need to use their medicines safely.

Inspector's evidence

The pharmacy’s entrance was level with the outside walkway in the shopping centre. This made it easier to enter the store for people who found it difficult to climb stairs. And the pharmacy team tried to make sure people could use the pharmacy services. The pharmacy had a notice that told people when it was open. Members of the pharmacy team were helpful. They spoke or understood Urdu, Romanian, Italian, Tamil and Bangladeshi to assist people whose first language was not English. If they could not advise and help them, they signposted people to another service provider such as other nearby pharmacies, the local hospital, genito-urinary clinic or NHS 111.

The pharmacy offered a repeat prescription service so people could order their prescriptions through the pharmacy. The pharmacy provided a delivery service to people who couldn’t attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy supplied medicines in multi-compartment compliance aids to people who had difficulty managing their medicines. The pharmacy team members checked if the medicines were suitable to be re-packaged. They provided patient information leaflets and a brief description of each medicine contained within the compliance aids. So, people had the information they needed to make sure they took their medicines safely. The dispensing assistant checked prescriptions for changes from last time such as changes in medication after a hospital stay. And kept a record of interventions.

Members of the pharmacy team initialled dispensing labels to show who had prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting. The pharmacy gave people a ‘due date’ and called the person when outstanding medicines were available to collect too. The RP explained the valproate pregnancy prevention programme. And counselling people in the at-risk group who were prescribed valproate on its contraindications. The pharmacy had the valproate information leaflets it needed. The pharmacy team had completed or were scheduled to do training in line with the pharmacy quality scheme (PQS) such as hypertension case-finding SOP, weight management, risk assessment, ‘lookalike and soundalike’ LASA medicines and inhaler technique. A poster was displayed encouraging people to return old inhalers to the pharmacy. The pharmacy had administered flu vaccinations to a number of people. It recorded NHS flu vaccinations on PharmOutcomes and offered to inform the doctors of people who had a private flu vaccination. It received a number of referrals for the community pharmacist consultation service (CPCS) mainly from NHS111.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within the original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines as part of their weekly audit of pharmacy systems. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, requiring safe custody, securely. The pharmacy had procedures for dealing with waste medicines which were kept separate from stock and were placed in one of its pharmaceutical waste bins. The pharmacy dealt with alerts and recalls about medicines and medical devices via the weekly audit. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources. The pharmacy had stamped glass measures for use with liquids, marked for use only with certain liquids. It had fridges for vaccines and other cold chain items requiring storage between two and eight Celsius. Fridge temperatures were monitored and recorded daily. The pharmacy team collected confidential waste for secure disposal. The pharmacy's computers and PMR were password protected and computer screens could only be seen by a member of the pharmacy team. And its team members used their own NHS smartcards. The adrenaline ampoules in the anaphylaxis kit were in date. The pharmacy team were expecting delivery of the equipment needed for the hypertension case-finding and weight management services.

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.