General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, Unit 21, Frenchgate Shopping Centre, Doncaster, South Yorkshire, DN1 1LF

Pharmacy reference: 9012243

Type of pharmacy: Community

Date of inspection: 21/05/2024

Pharmacy context

This community pharmacy is in a shopping centre in Doncaster city centre, it forms part of a larger retail and healthcare store. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a range of services including the NHS England Pharmacy First service, NHS blood pressure check service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

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 effectively identifies and manages the risks associated with providing its services. It keeps the records it needs to by law. And it keeps people's confidential information secure. Pharmacy team members respond to feedback from people using the pharmacy appropriately. They know how to act to protect a vulnerable person from harm. And they behave openly and honestly by discussing the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. The superintendent pharmacist's (SI's) team reviewed these at scheduled intervals. And new SOPs were introduced appropriately between these reviews to support the introduction of new services. Pharmacy team members discussed the learning they completed to confirm they understood the SOPs. But only the responsible pharmacist (RP) was able to demonstrate their training records during the inspection. Training records for other team members were provided shortly after the inspection. The records confirmed team members had completed relevant learning to support them in their roles. Team members were observed completing tasks safely and effectively throughout the inspection. A team member discussed the tasks they could not complete if the RP took absence from the pharmacy. Team members mostly followed the pharmacy's SOPs. But they did not always follow the SOP for accuracy checking medicines when an accuracy checking pharmacy technician (ACPT) completed the final accuracy check of a medicine. The SOP stated the clinical check should be conducted prior to dispensing tasks beginning. But team members described a process of completing dispensing and accuracy checking tasks prior to the pharmacist's clinical check of the prescription. The team demonstrated a clear process for ensuring a prescription was clinically checked prior to bags of assembled medicine being identified as complete and ready for collection.

The pharmacy had processes for managing mistakes its team members made and identified during the dispensing process, known as near misses. Team members discussed their mistakes and acted to correct them. They identified and implemented learning following them. For example, reviewing the placement of separators within the dispensary drawers. But they did not always record their near misses to help them identify trends in mistakes. This meant some opportunities to share learning may be missed. And some records of near misses made related to mistakes identified following the supply of a medicine to a person, known as dispensing incidents, rather than near misses. A team member identified that these had been mislabelled as near misses in error on the pharmacy's reporting system. The reports included full details of the incident, reflections on the mistakes and learning outcomes.

The pharmacy had a complaints procedure and team members felt confident in responding to concerns. Team members reflected on feedback they had received since the entire store had relocated from the ground floor to the first floor of the shopping centre around six months ago. Team members had promoted access arrangements to people, including the use of escalators and lifts within the centre in response to the feedback they had received. The pharmacy held people's confidential information in staff-only areas. And team members completed mandatory information governance learning. They disposed of confidential waste securely. Pharmacy team members completed learning to support them in recognising and reporting safeguarding concerns. And they knew what to do if somebody attended

the pharmacy wishing to access a safe space. They had resources and contact information available to support them in reporting a concern.

The pharmacy had current indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty and the RP record was completed in full. A sample of records made in the private prescription register were completed in accordance with legal requirements. The pharmacy maintained running balances in its controlled drug (CD) register. It completed regular checks of these balances against the physical stock it held. Random physical balance checks of CDs completed during the inspection matched the balances recorded in the CD register. The pharmacy held a record of the patient-returned CDs it received, and this record was maintained to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the skills and knowledge required to provide its services safely and effectively. Team members work together well and feel able to provide feedback at work. They engage in continual learning relevant to their roles. And they take some opportunities to share learning through team discussions.

Inspector's evidence

The RP on duty was the regular pharmacist, who was the pharmacy manager. They were relatively new in post and were supported well by the pharmacy's ACPT who held the role of team leader, a trainee medicine counter assistant (MCA) was also on duty. The pharmacy also employed a dispensing assistant, a pharmacy student, and a delivery driver. The team reported a current vacancy for a MCA. The team reported some pressures on staffing since moving to the new premises due to changes within the team and the current vacancy. Team members felt supported and explained they would reach out to the pharmacy's area manager when needed. And they provided examples of support provided to the team to ensure staffing levels remained appropriate.

Pharmacy team members received time and support with their learning during working hours. They engaged in conversations about their learning and development. They undertook regular learning to support them in keeping their skills and knowledge up to date. And they were supported with developing in their roles. For example, the trainee MCA was nearing the end of their course and they had identified their next learning steps with their line manager to support them in progressing into a dispensing role. The pharmacy was preparing to offer a smoking cessation service and had obtained appropriate information and training materials to support team members in their learning ahead of the service being introduced. The pharmacy team discussed the targets they were asked to meet when providing pharmacy services. They completed regular walks through the store to promote pharmacy services to people shopping in store. The RP described how they applied their professional judgment when conducting pharmacy services. This included using the skills of other team members trained to provide some services, such as the NHS blood pressure check service.

The pharmacy had a whistleblowing policy and its team members understood how to raise a concern at work. They worked well together and were confident in providing feedback to each other. A team member described the pathway they would follow if they needed to raise and escalate a concern in the workplace. Team members communicated with each other openly throughout the working day. They left some handover notes to support the safe management of workload. But they did not routinely take the opportunity to record conversations about mistakes they made during the dispensing process to help share learning.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and maintained well. Overall, it provides a professional environment for delivering healthcare services. People using the pharmacy can speak to a member of the team in a private consultation room.

Inspector's evidence

The premises were secure and in a good state of repair, they were clean and modern. Team members knew how to report maintenance concerns and there were no current maintenance issues reported. Lighting was bright and air conditioning in both the dispensary and consultation room provided a suitable ambient temperature for dispensing medicines and providing consultation services. Pharmacy team members had access to hand washing facilities equipped with antibacterial hand wash and paper towels. Hand sanitiser was also available for team members to use.

The pharmacy consisted of the medicine counter, dispensary, and a consultation room. The dispensary offered appropriate space for the level of activity taking place. An area at the far end of the dispensary was allocated to higher risk dispensing tasks such as the assembly of medicines in multi-compartment compliance packs. The consultation room was a good size but some clutter within the room, such as equipment stored on the work bench at the back of the room and waste medicine containers stored within the room did distract from the overall professional image of the private consultation space. Team members were observed using the room to provide pharmacy services throughout the inspection. The pharmacy had a locked storage space for archived records in the staff-only area of the wider store.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. Its team members complete regular checks to ensure medicines are safe to supply to people. And they take regular opportunities to identify and support people's health needs by promoting the pharmacy services available to them.

Inspector's evidence

The pharmacy was at the back of the store in a designated healthcare area, alongside a nurse-led health clinic. It advertised its opening hours and information leaflets provided people with details of the services it offered. Pharmacy team members had appropriate local knowledge of other pharmacies and healthcare services. They knew to signpost people to these organisations if they required a service or medicine the pharmacy could not provide.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. The RP had good supervision of this area and team members were observed asking appropriate questions when selling these medicines to assure themselves the sale was appropriate. Pharmacy team members engaged people in discussions about their health and wellbeing and were observed promoting services which may be of benefit to them. For example, the NHS blood pressure check service. They kept each other informed when taking people into the consultation room to provide a service which supported team members in managing workload and delivering the pharmacy's services effectively. The team had access to appropriate information including procedures, service specifications and Patient Group Directions when providing consultation services. The RP discussed how they referred to the clinical pathways when providing the NHS Pharmacy First service.

The pharmacy had some processes for identifying higher-risk medicines during the dispensing process. This included processes for applying additional checks when dispensing CDs and medicines requiring refrigerated storage. The team used stickers on bags of assembled medicines to identify the need to refer a person collecting medicines to the pharmacist for further counselling. But the team did not usually record these types of interventions on people's patient medication record (PMR) to support continual care. The ACPT and pharmacist discussed the requirements of the valproate Pregnancy Prevention Programme. The RP discussed the counselling they would provide when supplying valproate to people in the at-risk group. And the ACPT identified changes made to the PMR to support the supply of valproate in the manufacturer's original packaging.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. A team member demonstrated how the team managed prescription workflow, including sending messages to people via an application when their medicine was ready for them to collect. They generally signed their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. But a sample of some multi-compartment compliance packs had not been signed by the pharmacist who had provided the final accuracy check of the medicines inside the packs. The pharmacy's delivery service was currently unavailable to people due to absence within the team. Team members explained how they communicated this to people to ensure they were able to collect their medicines. The pharmacy kept a record of the medicines it owed to people. And the team made regular

checks to help ensure it obtained these medicines in a timely manner. It informed prescribers of concerns about the availability of medicines and had taken opportunities to advise prescribers of licensed medicines available when some unlicensed medicines were prescribed.

The pharmacy used individual records to support in supplying medicines in multi-compartment compliance packs. And it completed assessments with people to ensure supplying them with their medicines in compliance packs was the safest and most suitable way of supply for them. The individual records helped to identify changes to medicine regimens which the team checked with prescribers. The team kept some records of the checks they made in response to changes as they generally communicated with surgery teams via email. A sample of compliance packs examined were labelled clearly with descriptions of the medicines inside the compliance pack. But the pharmacy did not always provide patient information leaflets for the medicines it supplied in this way. This meant people may not have current information to support them in taking their medicines safely.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in an orderly manner within the original manufacturer's packaging. It held its CDs in a secure cabinet, and it held medicines requiring cold storage in suitable fridges, equipped with thermometers. The pharmacy kept temperature records for the fridges. And these records showed it was storing cold-chain medicines within the required temperature range of two and eight degrees Celsius. Team members recorded the expiry-date checks they made of the pharmacy's stock medicines. A random check of dispensary stock found no out-of-date medicines and medicines with short shelf lives were clearly identifiable. Team members annotated bottles of liquid medicines when opening them to show the opening date and details of any shortened expiry date. The pharmacy had appropriate medicine waste receptacles, CD denaturing kits and sharps bins available. It offered a recycling service for people wishing to return their empty blister strips to the pharmacy. It received medicine alerts through email, and it had a clear process actioning these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. And pharmacy team members use the equipment and facilities with care to protect people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and company intranet. They accessed both digital and hardcopy reference resources to obtain information. They used passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within a designated area of the dispensary. This arrangement prevented people's personal information on bag labels and prescriptions from unauthorised view. The pharmacy had a cordless telephone handset. The RP was observed moving out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy had a range of equipment to support it in delivering its services. A defibrillator was available on a workbench in the pharmacy's consultation room. A team member advised the machine was no longer in use. But it was not marked in any way to inform locum pharmacists or relief team members of this. And the expiry date of the contact pads within the machine had passed. Team members had access to standardised counting and measuring equipment when dispensing medicines. Equipment to support the delivery of consultation services, including the NHS Pharmacy First service was from recognised manufacturers and stored appropriately in the consultation room.

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.