General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Narborough Road South, Braunstone, LEICESTER, Leicestershire, LE3 2LL

Pharmacy reference: 1034118

Type of pharmacy: Community

Date of inspection: 29/05/2019

Pharmacy context

The pharmacy was situated in Asda supermarket. It had extended hours open from 8am to 10pm six days a week. The pharmacy provided the standard NHS services. It dispensed NHS and private prescriptions and sold over-the-counter medicines. In addition, it provided a range of medicines including travel services by private patient group directions.

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	Good practice	1.1	Good practice	Members of the pharmacy team are clear about their roles and responsibilities. They work to professional standards and identify and manage risks well.
		1.2	Good practice	The pharmacy has good processes for learning from mistakes and uses these to improve the safety and quality of the services it provides.
2. Staff	Standards met	2.3	Good practice	The pharmacy empowers its team members to act in the best interests of the people who use its services.
		2.5	Good practice	The pharmacy actively seeks its team's views on how to improve services and implements good suggestions.
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 ✔ Good practice

Summary findings

Members of the pharmacy team are clear about their roles and responsibilities. They work to professional standards and identify and manage risks well. The pharmacy has good processes for learning from mistakes and uses these to improve the safety and quality of the services it provides. The pharmacy adequately manages people's personal information. It asks its customers for their views and knows how to protect vulnerable people.

Inspector's evidence

The responsible pharmacist (RP) notice showing the pharmacist in charge of the pharmacy was displayed. During the day there was a cross-over period when two pharmacists are present. This allowed feedback on any issues or problems that had occurred and opportunity to complete other tasks such as management or clinical governance. The pharmacy also had a communication book so that messages about what had happened could be shared across the team. The pharmacy team had recently used it to make staff aware that GP surgeries were asking people to order prescriptions directly from them rather than through pharmacies and to make sure that customers were aware of the change.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) . SOPs were issued electronically, and the record checked showed that the member of staff was up to date. Staff were appropriately trained to deliver these services. For example, the staff signed the dispensed and checked by boxes on medicine labels and carried out weekly balance checks.

The pharmacy highlighted a range of medicines using stickers including controlled drugs (CDs); fridge items, MURs and pharmacist intervention. The stickers were to make sure that extra care was taken when handing out the medicines.

The dispenser was aware of the WWHAM questions to sell an over-the-counter medicine safely and she knew the advice that should be given. She was aware that prescriptions were valid for six months but explained that prescriptions were taken off the shelf after eight weeks. Dispensed prescriptions checked were within the eight week time period. She knew that CDs had a 28 day validity from the date on the prescription. She recalled some but not all the CDs that were not kept in the cupboard. She said that dispensed CDs had a sticker on them to make the person handing out the medicine aware. There weren't any dispensed CDs to be checked.

The pharmacy kept records of near misses, errors and incidents. The pharmacist explained the process for near misses. The near misses were returned to the member of staff to see if they could see the error; then reasons were discussed. The dispenser recorded the near miss in the near miss log. The log showed that the comments box and weekly review was completed. The pharmacist completed a monthly near miss review. The main problem highlighted in April's near miss review was dispensing the wrong quantities; the pharmacist said that when the quantity wasn't an original pack the final checker now wrote the number in the lid of the box as an additional check. An example was seen. Shelf barkers had been put on the stock shelves for look alike sound alike (LASA) medicines following guidance from head office. There was also a local error which had been highlighted in the same way. After a dispensing error a report was sent to head office who then send the pharmacy an action plan focusing on reducing risk. An audit trail was created through the use of dispensed by and checked by boxes. The final check

was by the RP.

Records to support the safe and effective delivery of pharmacy services were mainly legally compliant. These included the RP log, specials and the controlled drug register. Private prescriptions were recorded electronically. Records showed that entries didn't always record the prescriber; for example, a local private hospital was recorded instead of the prescriber.

There was a complaints procedure in place; the pharmacist would refer to his line manager or superintendent if necessary. There was information on how to complain in the pharmacy leaflet.

The results of the public consultation ending February 2019 were on display in the consultation room. 89% of people surveyed said that the service provided was excellent or good. People had raised concerns about the comfort and convenience of the waiting area. There was a small area to the side of the pharmacy which the pharmacist said people didn't see. He said that he was now signposting people to it.

Public liability and professional indemnity insurance were in place. Computer terminals were positioned so that they couldn't be seen by people using the pharmacy. Access to the electronic patient medication record (PMR) was password protected; each member of staff had their own Smartcard. Confidential paper work was stored online and in dispensary.

The pharmacy provided a range of services through private patient group directions (PGDs). This included travel services, emergency hormonal contraceptive and erectile dysfunction. Legal and in-date PGDs were seen. The pharmacist's training records were seen. Confidential waste was bagged and sent away for shredding.

The pharmacy only dispensed a small number of CDs. CDs were stored in a legally compliant CD cabinet. A random check of the recorded running balance of a CD reconciled with the actual stock in the CD cabinet. CDs were checked monthly. The pharmacy had a CD patient returns book. Patient returns were destroyed in a timely manner. Schedule 3 CDs were also recorded which was good practice. The pharmacist was aware of safeguarding requirements; there was guidance which had been read by all staff with local contact details available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members manage the workload within the pharmacy effectively. They work well together. The pharmacy empowers its team members to act in the best interests of the people who use its services. The pharmacy actively seeks its team's views on how to improve services and implements good suggestions. The pharmacy has a work culture of openness, honesty and training. People who work in the pharmacy do ongoing training to help keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. The pharmacy team was able to manage the workload to provide pharmacy services safely. During inspection there was one pharmacist and two trained dispensing assistants. For part of the inspection there were two pharmacists present. The pharmacy team engaged with the inspection process and worked well together, for example providing cover when the counter was busy.

The pharmacist said that there were now formal appraisals. Her appraisal had included reviewing her performance and allowed her to raise any concerns or issues. She said the process had been supportive and she had been asked how she could be supported in her development. She had been able to make suggestions on how to improve the pharmacy service by more effectively managing MUR patients. And better use of stickers by using fridge stickers instead of writing fridge on the prescription. Staff said that issues could be raised informally and there was the opportunity to give feedback and raise concerns.

The pharmacy team said there was informal training by the pharmacists. In addition, there was also training online. Head office issued SOPs or clinical training most months with a short test at the end to check understanding. Staff were up to date with training and recalled that the last training had been on dental health. Staff knew that CDs could now be sent on electronic scripts and that gabapentin and pregabalin were now controlled drugs and prescriptions were valid for 28 days from the date on the prescription. Although targets for services were set the pharmacist said they didn’t compromise customer service or her professional integrity.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. It protects people’s confidentiality. The premises are secure from unauthorised access when open and when closed.

Inspector's evidence

The dispensary was a reasonable size for the services provided, with an adequate dispensing bench available for the assembly of medicines and reasonable space for the storing of medicines. The dispensary was clean and tidy; there was a sink with hot and cold water. The pharmacy counter opened out onto the shop floor but there was a small area to the side of the pharmacy with two seats and a small range of leaflets.

The pharmacy had air conditioning to provide an appropriate temperature for the storage of medicines; lighting was sufficient. A reasonable size sound-proofed secure consultation room was available to ensure patients could have confidential conversations with pharmacy staff.

Computer screens were set back from and faced away from the counter. Access to the electronic patient medication record (PMR) was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. Its team members are helpful and give good advice to people. But some people who receive higher-risk medicines may not be getting all the information they need to take their medicines safely. The pharmacy gets its medicines and medical devices from reputable sources. It generally stores them safely. And it takes the right actions if any medicines or medical devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy was within a supermarket which provided flat access for a wheelchair or those with physical disability. The sign at the entrance of the store was covered by a temporary display. It was hard to see where the pharmacy was when entering the store. No signs for the pharmacy were seen until the pharmacy aisle. The sign advertising the services provided by the pharmacy was also covered by a temporary display.

Staff had uniforms and name badges; there was a hearing loop. There were a small range of health leaflets and a pharmacy practice leaflet was available. The pharmacist understood the signposting process and used local knowledge to direct patients who needed support from other healthcare providers.

The pharmacy used a dispensing audit trail which included use of dispensed by and checked by boxes. The pharmacy also used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of prescriptions. Work was prioritised based on whether the prescription was for a patient who was waiting or calling back.

The pharmacist was easily accessible to people using pharmacy services and was seen giving advice on over-the-counter (OTC) and prescription medicines. The pharmacy was very busy with customers purchasing OTC medicines. Dispensers gave advice or referred people when required. The pharmacist said that she provided a range of advice to people. This included dose changes or new medicines; she had a particular focus on children's medicines; she highlighted two scripts for antibiotics in the previous week where she had checked the dose for a child and it had been changed. She said that pharmacist gives out schedule 2 and 3 CDs including gabapentin, pregabalin and tramadol.

The pharmacy aimed to speak to people taking higher-risk medicines. However, the prescriptions waiting collection for warfarin and methotrexate didn't have a referral sticker which meant that the opportunity to speak to them might be missed. The pharmacist understood the risks with sodium valproate during pregnancy and the advice that should be given. A prescription was found for a person taking sodium valproate. It was in a white box. The warning sticker had been attached and the advice card put in the box. There was a note on the PMR to highlight the patient. The advice leaflets were on the stock shelves to remind staff to supply them.

The pharmacy was a Healthy Living Pharmacy. The pharmacy had a record of its campaigns for example for the Help Us to Help You campaign they had a display at the front of the shop to encourage use of and to advertise the pharmacy. The current campaign was for children's oral health.

Stock medicines were stored in their original containers on the shelf, fridge or CD cabinet as appropriate. Records showed that fridge lines were stored correctly between 2 and 8 degrees Celsius. Current temperatures were within range. The fridge was mainly well managed, but some medicines were pushed to the back of the fridge which increased the risk of them freezing.

The pharmacy carried out date checking every three months with records in the dispensary. Short dated stock was highlighted with sticker and recorded in a book. Out-of-date medicines were put in yellow waste bins; a patient returned CD register was in place. The pharmacy recorded the date of opening on all liquid medicines but the staff were not sure how long a medicine without a specific expiry period once open could be supplied. Two members of the team thought that it could be used for up to the original date of expiry on the bottle.

CDs were stored in accordance with legal requirements. Access to the cupboard was managed appropriately. There was a system in place for management of the CD key at the end of the day. Only recognised wholesalers were used for the supply of medicines. The pharmacist was aware of the procedure for drug alerts. There was an electronic audit trail. The pharmacy had started to implement the Falsified Medicines Directive.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers. It makes sure its equipment and facilities are adequately maintained.

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. The fridge was in working order with the current temperature within the required range; temperatures were recorded daily. CDs were stored safely. The pharmacy had an up-to-date reference sources.

Records showed that electrical appliance testing had been carried out in January 2019. The pharmacist wasn't sure how long the blood pressure machine had been used for but thought it was about a year. There was no indication such as a sticker showing the date; the pharmacist said that it was replaced by head office. Confidential paper records were stored securely. Confidential waste paper was bagged and sent away for shredding.

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.