General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Asda, Goddard Road, IPSWICH, Suffolk, IP1 5PD

Pharmacy reference: 1037167

Type of pharmacy: Community

Date of inspection: 04/07/2023

Pharmacy context

The pharmacy is in a superstore in a retail park, and it receives most of its prescriptions electronically. It provides NHS dispensing services, the New Medicine Service, blood pressure checks and flu vaccinations (seasonal). It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes who need this support. And it provides substance misuse medications to a small number of people.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy routinely records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
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	4.2	Good practice	The pharmacy manages its services well with a clear focus on patient safety.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It routinely records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And people can feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (SOPs). Dispensing mistakes identified before the medicine had reached a person (known as near misses) were managed well. The near misses were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were routinely recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Shelf edges were marked to indicate where medicines which looked alike and sounded alike were kept. And different strengths of the same medicines were kept in separate baskets, and these were clearly marked on the front with the strength. Following a recent near miss review, the different strengths of atenolol were now kept in separate baskets. Team members were not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The pharmacist explained that dispensing errors would be recorded on a designated form and a root cause analysis undertaken.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She knew that she should not sell any medicines or hand out dispensed items until the pharmacist had arrived. But she was unsure of some other tasks that should not be undertaken if there was no responsible pharmacist (RP) signed in. The inspector reminded team members what they could and couldn't do if the pharmacist had not turned up. Team members' roles and responsibilities were specified in the SOPs.

The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints. And he would refer any complaints to the pharmacy's head office.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription.

The private prescription records were largely completed correctly, but the correct prescriber details were not always recorded. The pharmacist said that he would ensure that these were recorded properly in future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be read by people using the pharmacy.

Team members had completed safeguarding training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with some ongoing training. This means that they can help improve the systems in the pharmacy. Team members can make professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets.

Inspector's evidence

There was one locum pharmacist, one trained dispenser, one trainee dispenser and one trainee medicines counter assistant (MCA) working during the inspection. Team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. This helped the pharmacy to ensure it was up to date with its dispensing.

The trainee MCA appeared confident when speaking with people. And she asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. She would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she was aware of the restrictions on sales of medicines containing pseudoephedrine.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had recently completed online training about the influenza vaccination service. And he had undertaken some learning about a skin condition following a person asking about treatment for it. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to make professional decisions. Team members said that team members were not provided with ongoing training on a regular basis, but they did receive some.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had performance reviews every six months. The pharmacist said that any issues could be discussed during the pharmacy manager's weekly conference call. Targets were set for the New Medicine Service. The pharmacist said that this service was provided for the benefit of some people using the pharmacy. And he would not let the targets affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were no chairs in the area outside the pharmacy. Team members said that people did not usually have to wait at the pharmacy for their prescriptions to be dispensed. This was because they regularly downloaded and dispensed the prescriptions it received electronically in advance of people coming to the pharmacy. There was a café inside the store near to the pharmacy where people could wait if needed.

The consultation room was accessible to wheelchair users and could be accessed from behind the medicines counter and the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were available in the main store. They were clean and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and stores them properly. It deals with drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. It ensures that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely. And people with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted with the date the prescription was valid until. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). If a person was not on a PPP and needed to be on one, they would be referred to their GP. The pharmacist said that people were supplied with whole packs of these medicines so that they received all the necessary information. And dispensing labels were positioned so that the warnings and information card on the packs were not covered.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office and any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Expiry dates were checked regularly, and this activity was recorded. And stock was stored in an organised manner in the dispensary. There were no date-expired items found in with dispensing stock when spot checks were carried out during the inspection. And medicines were kept in their original packaging. Items due to expire within the next several months were marked.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and kept separate from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

The dispenser said that uncollected prescriptions were checked regularly, and people were called if they had not collected their items after around two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked daily and 'owings' notes were provided when prescriptions could not be dispensed in full. People were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The dispenser said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The dispenser said that the people usually contacted the pharmacy if they needed these medicines when their packs were due. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were marked for use with certain medicines only. Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer's guidance. And the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.