General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, ASDA Superstore, 1 Tryst Road, Cumbernauld, GLASGOW, Lanarkshire, G67 1JW

Pharmacy reference: 1042513

Type of pharmacy: Community

Date of inspection: 27/09/2019

Pharmacy context

The pharmacy is in a large supermarket on the edge of Cumbernauld. It opens late in the evening. And it dispenses NHS prescriptions and provides a range of extra services. The pharmacy collects prescriptions from the local surgeries. And it supplies medicines in multi-compartmental compliance packs when people need extra help. A consultation room is available. And people can speak to pharmacy team members in private.

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 work to professional standards. They provide safe services and look after people’s welfare. The pharmacy keeps records of mistakes when they happen. But, it does not always share the information with the pharmacy team. And they don't always know the risks when they are dispensing. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure.

Inspector's evidence

The pharmacy used electronic standard operating procedures (SOPs) to define the pharmacy processes and procedures. The team members read the SOPs. And confirmed that they followed them. The company regularly reviewed and issued SOPs. And this made it easier for the pharmacy team to read and quickly adopt new processes. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And they had recently started recording their own errors on the company’s near-miss from. The team members were expected to provide a reason for the error. And this helped them to learn and avoid the same error happening in the future. The team members were unable to produce evidence that near-miss reviews were taking place. And they were not involved in any discussions about the dispensing risks that may have been found. The team members were unable to describe any improvement action from near-misses. But, they provided examples of look-alike and sound-alike medication they had separated and highlighted during routine tasks. Such as when they were putting the order away. For example, they had added caution labels to the shelves used for sertraline/sildenafil and amlodipine/amitriptyline medication.

The pharmacist managed the incident reporting process. And team members knew when incidents happened and what the cause had been. For example, they knew about a hand-out error when medication had been supplied to the wrong person. The pharmacist carried out a root cause analysis. But, the dispenser could not remember if they had asked the person to state their address. The pharmacist had instructed all the pharmacy team to re-read the hand-out SOP. And reminded them to always ask people to state their address. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used leaflets and a poster to inform people about the complaints process. The pharmacy received mostly positive feedback with no suggestions for improvement received.

The pharmacy maintained the legal pharmacy records it needed to by law. The pharmacist in charge kept the responsible pharmacist record up to date. And public liability and professional indemnity insurance were in place. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The team members recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction record. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions to improve access to medicines and advice.

And a sample levonorgestrel patient group direction was valid until 2020.

The pharmacy displayed leaflets and a notice to inform people about its data processing arrangements. And the team members knew how to safeguard personal information. The pharmacy team disposed of confidential information in designated bags. And a collection service uplifted the bags for off-site shredding. The pharmacy stored prescriptions for collection out of view of the waiting area. And kept computer screens facing away from the waiting area. The pharmacy team took calls in private using a portable phone when necessary. And used a password to restrict access to medication records. The company had registered the pharmacists with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company had trained its team members to recognise the signs and symptoms of neglect or abuse. But, they could not remember the training or what the outcomes had been. The team members had completed dementia friends training. And they knew to refer concerns to the pharmacist. For example, they contacted the community addictions team (CAT) after three days if people did not arrive for medication that needed close supervision.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance and identify and discuss their learning needs at review meetings to keep up to date in their roles. The pharmacy encourages and supports the team members to learn and develop. And they support each other in their day-to-day work.

Inspector's evidence

The pharmacy had experienced a 10% increase in the number of NHS prescriptions it dispensed. And the lead pharmacist monitored the capacity and capability of the pharmacy to ensure it was able to provide the pharmacy services. The company had not replaced a team member who had left six months previously. But, the lead pharmacist had been authorised to use an over-time budget to make-up for the shortfall. And this had been spent on over-time. The lead pharmacist produced separate rotas for the pharmacists and the dispensers. And only one person from each team was permitted leave at the one time. A sample rota showed a greater number of team members providing cover at busy periods. For example, between the hours of 5.00pm and 7.00pm.

Four part-time pharmacists had worked at the pharmacy for a significant length of time. The pharmacists mostly worked on their own. But second pharmacist cover was provided for five hours every Thursday. The pharmacy used an annual appraisal to identify areas for development. And the company encouraged and supported the team members to develop. The lead pharmacist used the rota to schedule protected training time for Thursdays, Fridays and weekends. And a locum pharmacist who had recently taken up a substantive post was undergoing 12 weeks of managerial training at an off-site location. The pharmacists had completed the necessary training to provide the flu vaccination service. And the dispensers had completed an e-learning module to carry out the initial consultation, and complete the necessary records. The company provided regular e-learning so that team members were up-to-date with new initiatives and changes. And a sample record showed the team member had completed the following training; dementia friends, Migraitan for the relief of migraines and high risk medicines including warfarin, lithium and methotrexate.

The company had trained the team members to deliver the smoking cessation service. And health board staff provided on-site training to ensure they were up-to-date with any changes. For example, the dispenser knew that people could re-register with the service a week following a relapse. The company trained team members to carry out blood pressure monitoring. And dispensers referred high readings to the pharmacist. A new team member had been trained to monitor requests for medicines that were liable to abuse, including codeine containing products. And they were keeping records that they shared with colleagues due to the pharmacy's extended opening times. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had suggested that the second chip and pin reader was re-instated at the medicines counter so they could manage queues more effectively.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean. And the pharmacy provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy’s waiting area presented a professional image to the public. And it provided seating and displayed patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the pharmacist supervised the medicines counter from the checking bench so they could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a safe and comfortable environment from which to provide services. The pharmacy provided a consultation room which was professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know about its late opening hours and what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had step-free access. And it provided a lowered counter and hearing loop for people with access difficulties. The pharmacy displayed its opening hours in the pharmacy window. And displayed leaflets in the waiting area and in the consultation room. The pharmacy dispensed prescriptions for a significant number of people who wanted to wait on their medication being dispensed. And the team members knew to suggest that people returned to collect it after they had completed their shopping. The team members were trained and accredited to work both on the medicines counter and in the dispensary. And they knew to prioritise dispensing so that people didn't have to wait long. The pharmacy team used dispensing baskets to keep medicines contained throughout the dispensing process.

The pharmacy dispensed multi-compartment compliance packs for around six people. The team members had read and signed the company's standard operating procedure. And this ensured that dispensing was safe and effective. A rear bench was used to assemble packs. And this minimised disruptions and the risk of dispensing errors. The team members removed and isolated packs when they were notified about prescription changes. And a note was made in the patient medication record at the time of the change. The pharmacy did not always supply patient information leaflets, But, they routinely provided descriptions of medicines. The team members dispensed methadone doses for around 19 people. And dispensed the doses on a Sunday when it was quieter. The pharmacist carried out accuracy checks before doses were put away in the controlled drugs (CD) cabinet. And the team members retrieved doses for the pharmacist to supply when they were needed.

The team members kept the pharmacy shelves and drawers neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy kept controlled drugs in two well-organised cabinets. And kept methadone doses separated in baskets to manage the risk of selection errors. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs during regular checks. The pharmacy used two fridges; one for stock and the other for dispensed medicines awaiting collection or for delivery. And the team members monitored and recorded the fridge temperatures to demonstrate that the temperature had remained between two and eight degrees Celsius. The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And an audit trail was kept to provide evidence that action had been taken. For example aripiprazole medication had been checked in August 2019 with records showing that no stock had been found. The pharmacy team members had learned about the

requirements of the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards. The dispensers confirmed that the regular pharmacists monitored prescriptions for valproate. But, a sample PMR record had not been annotated to confirm that safety checks had been carried out. And the regular pharmacists needed to carry out a review to confirm that records were being kept and accessible to the pharmacy team. The pharmacy team had been trained about the Falsified Medicines Directive (FMD). And the system had been implemented. But the team members had not been able to use the system over the past few weeks due to access difficulties. And they had escalated the issue and were awaiting instructions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And the team members had labelled the measures for methadone and antibiotic syrups. The pharmacy team members used a blood pressure monitor. And although the team members believed that the monitor was relatively new. They were unable to confirm when it had first been used. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.