General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Murray Street, LLANELLI, Carmarthenshire, SA15 1BX

Pharmacy reference: 1087817

Type of pharmacy: Community

Date of inspection: 26/04/2019

Pharmacy context

This is a pharmacy set inside a large supermarket in a town centre. It sells a range of over-the counter medicines and dispenses NHS and private prescriptions. Most people who use the pharmacy do so while they are shopping at the supermarket. The pharmacy provides a range of services including blood pressure checks, treatment for minor ailments, smoking cessation, emergency hormonal contraception and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse treatment services are also available.

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	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 has written procedures to help make sure the team works safely. But its team members do not always record or review their mistakes. So it is likely that some chances to learn from them might be missed. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses, although very few near misses had been recorded in recent months and it was likely that some incidents had not been captured. There was no evidence available to show that near misses were regularly reviewed.

Some action had been taken to reduce risk: methadone mixture and sugar-free methadone oral solution had been separated in the CD cabinet to avoid picking errors. The pharmacist demonstrated that amlodipine and amiodarone tablets had been separated at the direction of a head office patient safety bulletin, following a dispensing incident that had occurred in another store. Staff were aware of the risks of picking errors with 'Look-Alike. Sound-Alike' drugs, such as atenolol, amlodipine and amitriptyline and demonstrated that these were not stored closely together on dispensary shelves. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

A range of electronic Standard Operating Procedures (SOPs) underpinned the services provided; these were regularly reviewed. Staff had completed an online declaration and assessment for each SOP. A list of daily and weekly tasks was displayed on the dispensary noticeboard for reference.

The pharmacy received regular customer feedback from annual patient satisfaction surveys; the results of the most recent survey displayed in the consultation room showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed near the consultation room.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including Responsible Pharmacist (RP), private prescription, emergency supply, specials procurement and Controlled Drug (CD) records. However, records were not always made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors: some specials procurement records did not include patient details and some headings were missing from CD registers. CD running balances were typically checked weekly.

Staff had received training on the information governance policy and evidence of signed confidentiality agreements was available. One staff member had yet to complete refresher training but was aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords that the system

prompted them to change at regular intervals. A notice in the waiting area signposted customers to the company website for information on how their personal data was managed and used.

The pharmacists had undertaken formal safeguarding training and had access to guidance and local contact details that were available via the internet or through Local Health Board staff contacts. Staff were in the process of completing in-house training; the trainee dispenser was able to identify basic safeguarding concerns and said that she would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary. A notice displayed near the consultation room encouraged customers requiring a chaperone to speak to a member of staff.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. But sometimes there is only one staff member working with the pharmacist. This means that if the pharmacy is busy at these times it cannot provide services as effectively as usual. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They can speak up about the way the pharmacy works.

Inspector's evidence

Two pharmacists oversaw all professional activities as part of a job-share. Their shifts overlapped for a few hours every Thursday. Locum pharmacists covered their absences, although the regular pharmacist said that she was currently working a 12-hour shift on her day off, as the locum pharmacist who had been booked to work had cancelled at the last minute. She said that the same had happened with the locum pharmacist due to be working the next day and she was trying to find suitable cover as she did not want to work another long shift; after several telephone calls the issue was resolved.

The pharmacy was very busy during the initial period of the inspection, with one pharmacist and one member of staff on duty. There was a backlog of work, with some customers being advised of a 20 to 30-minute wait for prescriptions, and the team said that they felt under pressure. However, when another member of staff joined the team shortly afterwards they were able to comfortably manage the workload and the staffing level appeared adequate for the services provided. Certificates were displayed as evidence that most staff members had the necessary training and qualifications for their roles; a trainee dispenser worked under the pharmacist's supervision.

Targets were set for MURs but these were managed appropriately and the pharmacist said they did not affect her professional judgement or patient care. She said that there was some pressure to complete MURs and she was not always able to do so due to staffing numbers.

Staff worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and raise concerns with either the pharmacists or store manager. A whistleblowing policy advertising an anonymous and confidential helpline for reporting concerns was available on the intranet; the pharmacist printed this out during the inspection and displayed it in the dispensary.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. A computer terminal which allowed staff to access patient medication records to help them make decisions about sales of medicines or provision of advice was situated at the medicines counter; no confidential information could be seen from the retail area.

Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services; they had recently completed training on asthma and allergies and the Falsified Medicines Directive.

Staff also had access to informal training materials such as articles in trade magazines and information

about new products from manufacturers. All had recently completed training provided by NHS Wales on improving the quality of services provided. The staff member present said that she had not had a formal appraisal but could discuss performance and development issues informally with the pharmacists or personnel manager whenever the need arose. The lack of a structured performance and development programme increased the risk that opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and is tidy and secure. It has enough space to allow safe working and its layout protects people's privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised; the dispensary was small but had enough space to allow safe working. The sinks had hot and cold running water and soap and some cleaning materials were available. Staff said that a store cleaner changed the bins and wiped the floor every day during working hours, except for Sundays.

A plastic strip curtain at the entrance to the dispensary was used to keep in heat, as the pharmacy's proximity to a shopping mall entrance made it quite cold. The curtain also kept out dust and was grubby: staff said that the dust was ingrained from years of use and could not be removed using the cleaning materials they had available. A locked consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that most people can access easily. If the pharmacy can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. And it generally manages medicines well. But it doesn't always make sure that people taking high-risk medicines are given additional advice they may need to use their medicines safely.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. An air conditioning unit situated near the medicines counter was noisy and staff said it was sometimes difficult to communicate with patients who were hard of hearing, or for whom English was not their first language; however, a loop was available to assist people with hearing aids.

A list of local sexual health clinics was displayed in the dispensary for reference and staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. The pharmacy had some health promotional material on display in the waiting area. The pharmacy collected prescriptions from about seven local surgeries but did not provide a delivery service.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine.

The pharmacist said that she self-checked some prescriptions as there was not always a dispenser present. She was aware that self-checking could increase the risk of errors but she said she always took a mental break between the dispensing and checking processes. She also ensured that she labelled and dispensed items in one area of the dispensary and then moved the items to a separate area before checking them.

Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR and to alert staff to the fact that a CD or fridge item was outstanding. Stickers were sometimes used to identify dispensed Schedule 3 and 4 CDs awaiting collection; occasionally there was no sticker but the date on the prescription was circled to alert staff to the fact that it should not be supplied to the patient or their representative more than 28 days after this. However, one prescription for gabapentin and another for diazepam awaiting collection were not marked in any way. As the process in place for identifying Schedule 3 and 4 CDs awaiting collection is not robust, there is a risk that dispensed medicines may be supplied to patients against an invalid prescription.

Stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. Staff said that they recorded relevant information about blood tests and dose changes on the patient medication record (PMR), although there was no evidence of this available at the time of the inspection. The pharmacist said that one patient prescribed valproate who had met the eligibility criteria for risk had been counselled and had received patient

information explaining the risks of use during pregnancy. She said that the patient no longer used the pharmacy.

Disposable MDS trays were used to supply medicines to two patients who had compliance difficulties. Trays were labelled with descriptions and patient information leaflets were routinely supplied. A labelled box for each patient contained their current prescription, personal and medication details and details of any messages. Medicines were obtained from licensed wholesalers and stored appropriately including those requiring cold storage. CDs were stored appropriately in a tidy, well-organised CD cabinet and obsolete CDs were segregated from usable stock.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacist was able to describe how she had dealt with a recall for Ventolin Accuhalers by contacting patients and returning quarantined stock to the relevant supplier. Evidence was kept to show that drug recalls were logged and actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities needed to provide services. These are safe and generally suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids; separate measures were used for methadone. Triangles and capsule counters were used to count tablets and capsules; a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.

Most equipment was in good working order, clean and appropriately managed, although the endorsement printer was not working properly during the inspection and the pharmacist reported this as a fault. The PMR software programme crashed during the inspection and staff fixed the problem by rebooting the system; they said that this happened quite often. Evidence showed that electrical equipment had recently been tested.

Equipment and facilities were used to protect the privacy and dignity of patients and the public: for example, the computer was password-protected and the consultation room was used for private consultations and counselling.

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.