General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, East Street, Bedminster, BRISTOL, Avon, BS3 4JY

Pharmacy reference: 1092810

Type of pharmacy: Community

Date of inspection: 07/06/2019

Pharmacy context

This is a community pharmacy located inside a supermarket in Bristol. A range of people use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS). And, it supplies some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time.

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	2.2	Good practice	Team members have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training
		2.4	Good practice	The pharmacy's team members are provided with resources to help keep their knowledge up to date. The team has adopted a culture of openness, honesty and learning.
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 identifies and manages most risks effectively. Members of the pharmacy team monitor the safety of their services by recording mistakes and learning from these. They understand how they can protect the welfare of vulnerable people. And, they protect people's privacy well. In general, the pharmacy maintains most of its records in accordance with the law.

Inspector's evidence

The pharmacy held a range of electronic Standard Operating Procedures (SOPs) to support its services. These were reviewed recently, members of the pharmacy team had read the SOPs, they could easily access them and described using them when they needed to check processes. Staff were clear on their roles and responsibilities, they knew when to refer to the Responsible Pharmacist (RP) and which activities were permissible in the absence of the RP. The pharmacist's RP notice was on display and this provided details about the pharmacist in charge of operational activities. However, the notice provided a different first name to the pharmacist's name that was registered with the General Pharmaceutical Council (GPhC) and this could be misleading to the public. The pharmacist was asked at the outset whether the details on the notice were his, this included his first name which was confirmed by him at the time.

The pharmacy was organised; this included the way its stock was arranged and the dispensary as well as the main work bench, which was kept clear of clutter. The workload was manageable. Staff and pharmacists recorded details of near misses, they were reviewed every week and at the end of every month. Key learning points were recorded, and a briefing occurred to inform staff. Team members explained that they checked stock initially when prescriptions were received, their stock was held in an alphabetical arrangement and if they became aware of medicines that were of similar packaging or of “high risk”, they were separated. This included moving quinine away from quetiapine and these measures helped to minimise risks.

A notice was on display to inform people about the pharmacy’s complaints process. However, this was hidden from view due to a stack of totes that were placed next to it. Hence, the details could not be easily seen. The RP’s process involved checking relevant details, investigating, recording details so that this information could be passed to the regular pharmacist and the pharmacy’s head office as well as informing the person’s GP if any incorrect medicine was taken.

The team was trained on data protection through reading SOPs, staff had signed confidentiality clauses and were trained on the EU General Data Protection Regulations (GDPR). Online information was provided by the company to assist with the latter. Staff ensured that all confidential material was contained within the dispensary and they segregated confidential waste before it was shredded. There was no confidential information present in areas that were accessible to the public, and sensitive details present on bagged prescriptions awaiting collection, could not be seen from the front counter. The pharmacy informed people about how it maintained their privacy, and this was through a notice that was on display. The RP had accessed Summary Care Records, this was in the evenings for emergency supplies or for queries and consent was obtained verbally.

Staff could identify signs of concern to safeguard vulnerable people, they referred to the RP in the first instance. Staff had read the company’s SOP as part of their training and the pharmacist was trained to

level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). There were also relevant local contact details on display and readily accessible.

Records for the maximum and minimum temperature of the pharmacy fridge, were maintained to verify appropriate cold storage of medicines and the pharmacy held a complete audit trail for the destruction of returned CDs.The RP record was complete but the pharmacist on the day of the inspection had signed out before his shift had finished.

A sample of registers checked for Controlled Drugs (CD), records of emergency supplies, most records of private prescriptions and unlicensed medicines were maintained in line with statutory requirements. Staff ensured balances for CDs were checked and documented every week and this included regular checks for overages of methadone. On selecting random CDs (Shortec and Zomorph) held in the CD cabinet, their quantities corresponded to the balance stated in registers. Odd electronic records of private prescriptions held an incorrect prescriber address and odd records for unlicensed medicines were missing details of the prescriber. Professional indemnity insurance arrangements were in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members understand their roles and responsibilities. They keep their skills and knowledge up to date by completing regular training.

Inspector's evidence

The pharmacy dispensed approximately 5,000 prescription items every month, with 36-40 people receiving their medicines inside Monitored Dosage Systems (MDS) and 12 people with instalment prescriptions.

Staff at the inspection included a regular locum pharmacist and two trained dispensing assistants. There were also two other regular pharmacists and three further dispensing assistants, one of whom was enrolled on accredited training with Buttercups as well as a new starter, whose employment had commenced the week before the inspection. The team's certificates of qualifications obtained were seen and staff present were wearing name badges. Contingency arrangements for absence or annual leave involved team members covering one another.

Staff were observed asking a range of relevant questions before selling over-the-counter (OTC) medicines, they referred to the RP when required, the team was aware of medicines prone to abuse and described refusing sales of medicines if excess requests were seen. The new member of staff was described as reading through the company's SOPs and staff supervised any transactions made by them.

Staff explained that they all knew what their jobs were, they worked well together and were confident to raise concerns as well as talk through issues if needed. A book was used to help communicate between them and to help with training needs, staff read SOPs, updates were provided through the company, they used instruction from pharmacists and completed relevant courses on the company's online platform. Their progress was also regularly checked. The locum pharmacist explained that he had not been set any formal targets to achieve services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a professional environment to deliver its services.

Inspector's evidence

The pharmacy was situated at one end of the supermarket, its premises consisted of a small sized retail space/front counter, a medium sized dispensary and a signposted consultation room, located at one end of the front counter. The room was used for confidential conversations and services, it was of a suitable size for this purpose and there were two entry points. One entrance was from behind the front counter, the other was from the retail space. The latter was kept locked and there was no confidential information present or accessible from inside this area.

The pharmacy was bright, suitably ventilated and presented. All areas were clean.Pharmacy only (P) medicines were displayed behind the front counter. There was a barrier into this area which assisted in restricting their self-selection as well as access into the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable sources and stores most of its medicines appropriately. But it has no containers to store and dispose of some medicines that could be harmful to the environment. In general, the pharmacy provides its services safely and effectively. But, team members don't always highlight prescriptions that require extra advice or record information. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied. And, the pharmacy does not always provide medicine leaflets. This means that people may not have all the information they need to take their medicines safely.

Inspector's evidence

People could enter the supermarket at street level from automatic doors and escalators. The supermarket was made up of wide aisles and the area outside the pharmacy consisted of clear, open space. This enabled people requiring wheelchair access to easily use the pharmacy's services. The pharmacy's opening hours were on display, there were ample car parking spaces outside and two seats available for people waiting for prescriptions. Staff described using written communication to assist people who were partially deaf, colleagues in the store physically assisted people who were visually impaired, and representatives or phones were used to help people whose first language was not English.

The team was aware of the risks associated with valproate, they had been trained on this by reading and seeing information online. Staff explained that an audit was completed in the past to identify females of child bearing potential, that were supplied this medicine. According to the team, the regular pharmacist had contacted females at risk, or where representatives had picked up the prescription on their behalf to ensure counselling occurred. Relevant material to provide to people about this was also present.

Although staff were aware that some checks should be made for people prescribed higher-risk medicines and the RP explained that blood test results were asked about, prescriptions for people prescribed these medicines were not routinely identified, as requiring pharmacist intervention and there were no details seen documented about whether the staff had checked relevant parameters. This included recording the International Normalised Ratio (INR) level for people receiving warfarin.

MDS trays were supplied to people after their GP assessed suitability and liaised with the pharmacy team. Once set up, staff ordered prescriptions and when received, they cross-referenced details against individual records to help identify changes or missing items. Team members were also informed of changes by the GP surgery and retained discharge information that was provided by the hospital. The team checked queries with the prescriber and maintained records to verify this. Trays were not left unsealed overnight, descriptions of medicines within trays were provided and all medicines were de-blistered into trays with none left within their outer packaging.

The inspector was told that Patient Information Leaflets (PILs) were only supplied at the outset and for changes or new medicines. People prescribed warfarin were provided this separately but details about INR levels were not documented. Mid-cycle changes involved retrieving the old trays, amending them and re-supplying to people.

During the dispensing process, staff used baskets to hold prescriptions and associated medicines. This helped to prevent any inadvertent transfer. Staff used a dispensing audit trail, through a facility on generated labels to identify their involvement in processes. Prescriptions when assembled were held within an alphabetical retrieval system. Team members could identify fridge items and CDs (Schedules 2-3) when handing out prescriptions from their own knowledge. In addition, stickers were used to identify these medicines on the prescriptions. Staff described removing uncollected items every month. Schedule 4 CDs were not identified and although staff were checking prescriptions every month, the new starter may not have recognised these prescriptions or their 28-day prescription expiry. Routinely identifying all CDs as best practice was discussed during the inspection. Assembled CDs and medicines that required cold storage were held within clear bags, this helped to assist with accuracy and identification when handing out to people.

The pharmacy obtained its medicines and medical devices through licensed wholesalers such as Alliance Healthcare and AAH. Unlicensed medicines were obtained through the latter. The team was informed of the process required under the European Falsified Medicines Directive (FMD), staff had read the relevant SOP and scanners were present. However, they explained that the pharmacy's system was not currently set up for the process, hence they were not yet scanning any medicines.

The pharmacy's stock holding was organised, the team date-checked medicines for expiry every week and used a schedule to help verify this. Date-expired medicines were clearly segregated and there were no mixed batches seen. Short-dated medicines were identified using stickers and liquid medicines were marked with the date that they were opened. CDs were stored under safe custody and the key to the cabinet was maintained in a manner that prevented unauthorised access during the day as well as overnight. A CD key log was maintained as an audit trail to verify the latter.

Drug alerts and product recalls were received through the company system, staff checked stock and acted as necessary. A complete audit trail was present to verify the process. Medicines brought back by the public for disposal were accepted, staff checked for CDs and sharps, they referred people bringing back sharps for disposal, to the local council. Returned CDs were brought to the attention of the RP and relevant details were entered into a register. However, staff present could not easily identify hazardous or cytotoxic medicines, there were no bins present to segregate and dispose of these medicines safely and no information present to assist the team in identifying hazardous or cytotoxic medicines requiring disposal. The team was therefore placing these medicines into the same containers even though there was a notice on the wall that told staff that they should be separating hazardous and cytotoxic medicines into designated bins.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services safely.

Inspector's evidence

The pharmacy was equipped with current versions of reference sources. The CD cabinet was bolted in accordance with statutory requirements.The fridge stored medicines at appropriate temperatures. There were clean, crown stamped, conical measures available for liquid medicines and designated ones to use for methadone. The team could also use counting triangles, and this included a separate one for cytotoxic medicines.

The sink in the dispensary used to reconstitute medicines was clean, there was hand wash as well as hot and cold running water available. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. A shredder was present to dispose of confidential waste. Staff used their own individual NHS smart cards when accessing electronic prescriptions and took them home overnight.

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.