General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Anton Mill Road, ANDOVER, Hampshire, SP10 2RW

Pharmacy reference: 1093208

Type of pharmacy: Community

Date of inspection: 18/02/2020

Pharmacy context

A supermarket pharmacy situated on the edge of Andover town centre. As well as NHS essential services the pharmacy has an extended-hours dispensing service. And provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and blood pressure checks. The pharmacy also provides medication for malaria prophylaxis and seasonal flu vaccinations. And provides prescription services for substance misuse clients.

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	2.5	Good practice	Team members are good at making suggestions and implementing changes which will improve the pharmacy's services.
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's working practices are safe and effective. Its team members understand their responsibilities in helping to protect vulnerable people. They listen to people's concerns and keep their information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. The pharmacy has adequate insurance in place to help protect people if things do go wrong.

Inspector's evidence

The pharmacy had procedures for managing risks in the dispensing process. Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. They had standard operating procedures (SOPs) to follow, and, it was clear that team members understood those relevant to their roles. The team had procedures for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and were usually recorded. Near misses and errors were discussed to highlight any mistakes and reduce the chance of reoccurrence. But in recent weeks the pharmacy had not been able to record all of its mistakes or review them. As staff were allocating most of their time to getting prescriptions ready on time for people. Staff said that during this time they had been busier than usual due to staff shortages. But the team always discussed its mistakes and it was clear that team members were very aware of certain types of risk. They were aware of risks associated with 'look-alike, sound-alike' products (LASAs). And so, had discussed and highlighted the risk of mistakes between amitriptyline and amlodipine, ropinirole and rosuvastatin. Staff had also discussed the potential for error when dispensing different forms of the same product such as salbutamol inhaler and salbutamol breath actuated inhaler.

The pharmacy team had a positive approach to customer feedback. Last year's patient questionnaire showed a very small number of respondents would like a more private area for confidential conversations. So, staff said they offered the use of the consultation room to patients regularly. The room also had a large sign on the door to make it more obvious to people. And staff had moved a sunglass stand, which previously stood in front of it. The team described how, when costs and availability allowed, they ordered the same brands of medicines for certain people to help them with compliance. Customer preferences included the Teva brand of atenolol and temazepam. The team added notes to individual patient medication records (PMRs) to act as a reminder for themselves when dispensing and checking items for these patients. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the RP and formal complaints referred to the Superintendent (SI). Staff said that complaints were rare but if they were to get a complaint it would be recorded. Details of the complaints procedure and invitation for feedback was available in a pharmacy leaflet. And staff could find details for local NHS complaints advocacy and PALS on line. The pharmacy had professional indemnity and public liability arrangements in place which was renewed annually. Insurance arrangements were there to provide insurance protection for staff and customers.

All the necessary records were kept and were generally in order including those for controlled drugs (CDs), emergency supplies unlicensed 'Specials' and the RP. The team also kept records of CDs, which had been returned by patients, for destruction. This was to ensure that they were traceable and accounted for. Staff were aware of the need to protect patient confidentiality. Records for private

prescriptions were in order. But the pharmacy had yet to obtain the original prescription for a prescription only medicine dispensed against a faxed prescription on 21 December 2019. Discarded patient labels and other patient sensitive documents were put into a basket during the working day. The contents of the basket were shredded regularly. Staff had been trained on information governance and the importance of protecting patient confidentiality. And prescriptions were stored such that names and addresses could not be seen from the customer area. Staff were aware of the importance of safeguarding vulnerable adults and children. Pharmacists had completed training to CPPE level 2, and all other regular staff had undergone safeguarding training. Contact details for the relevant safeguarding authorities were available online. The team had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

In general, the pharmacy team manages the workload safely and effectively and team members work well together. And they are good at making suggestions and implementing changes which improve the pharmacy's services. But the pharmacy does not always have enough staff to allow it to keep up to date with all of its tasks.

Inspector's evidence

The pharmacy had two regular RPs including the pharmacy manager. The pharmacy also had regular locums to cover additional shifts and holidays when required. On the day of the inspection services were provide by a locum pharmacist, a trainee dispenser and a trainee medicines counter assistant (MCA). One of the regular pharmacists arrived towards the end of the inspection. But the pharmacy was operating with fewer staff then usual due to sickness and other absence. And although customers were served promptly the pharmacy was over two days behind with the dispensing workload.

The trainee dispenser said she had not had a formal review but had regular informal discussions with her manager, pharmacists and other colleagues and felt able to raise concerns with them. Team members were observed to work well together. It was evident that they could discuss matters openly, and they were seen assisting each other when required. The trainee dispenser described how she and her colleagues had suggested that they should not overstock on dispensing items due to the limited amount of storage available. As a result, stock was ordered as it was needed. And it was generally obtained and dispensed in time for people to collect. The trainee dispenser described how she tried to help people with queries of shortages of medicines, particularly hormone replacement therapy (HRT). She accessed the information directly from the British Menopausal Society website and was able to direct patients back to their GPs with suggestions as to what was available during the current shortage.

When the regular pharmacists were on duty there was a period of double cover for two to three hours which allowed each pharmacist to have break. The overlap time also allowed for provision of services, such as MURs and flu vaccinations, when workload allowed. The pharmacist was able to make his own professional decisions in the interest of patients and offered services such as an MUR when he felt it beneficial for someone. All pharmacists were targeted with managing the daily workload and to provide additional services when it was appropriate to do so. A note had been placed on the computer requesting that pharmacists complete five MURs per week. But the locum pharmacist on duty was unable to provide any that day as he focused on the dispensing workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services. But the pharmacy does not have enough storage space.

Inspector's evidence

The pharmacy was located at the top of the escalator entrance into the store. It stocked a core range of counter medicines. And general healthcare products were stocked in the general store area close by. When they could, staff would often help customers find the items they needed in the main store. The pharmacy had a traditional layout with the counter at the front and the dispensary behind. It had a consultation room adjacent to the counter. And two chairs for waiting customers. Pharmacists used the consultation room regularly for services such as MURs. The room was sealed at the top and the general background noise in the store meant it was unlikely that confidential conversations could be overheard. When not in use the consultation room door was kept locked from the shop floor entrance in the interests of security and safety.

The pharmacy's dispensary had an approximately eight metre run of dispensing bench. Work surfaces were well used with separate areas for assembly labelling and accuracy checking. But a predominance of pharmacy equipment and dispensing baskets meant that there was not much free space. Floor space was also taken up with Doop bins and bulky stock. But the pharmacy remained organised. Stock was stored in an organised fashion and staff tried to keep it tidy by putting stock and paperwork away as soon as they had finished with them. Sinks, floors, and work surfaces were all clean. The pharmacy was bright and well ventilated with temperature control systems in place. And it had a professional appearance. Access to the dispensary was at the discretion of the pharmacist.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. The pharmacy generally manages its medicines safely and effectively. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. But it does not store all of its medicines appropriately, once they have been removed them from their original packs.

Inspector's evidence

The store had a step-free entrance and it had signage outside to let people know it had a pharmacy. The store's escalator, leading up to the pharmacy, was suitable for wheelchairs. The store area around the pharmacy was free of unnecessary clutter. And so, wheelchair users could access pharmacy services. Signs for the pharmacy had been positioned at the top of the escalator and on the wall above the pharmacy. There was a list of pharmacy services on the wall outside the consultation room, and a small range of health information leaflets.

In general, staff appeared to be providing services in accordance with standardised procedures. CDs were audited on a regular basis as per procedure. And a random check of CD stock indicated that the running balance quantity in the register, was correct. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail, as per the SOP. The pharmacy had procedures for targeting and counselling all patients in the at-risk group taking sodium valproate. Staff said that, where appropriate, they would counsel patients and include valproate warning cards with prescriptions. Packs of sodium valproate in stock bore the updated warning labels. Malarone anti-malarial products were supplied in accordance with an up-to-date PGD. The pharmacy kept records of all consultations and details of the product supplied.

Medicines were obtained from licensed wholesalers and stored appropriately. Wholesalers used included Alliance Healthcare, AAH, and Sigma. Unlicensed 'specials' were obtained from AAH. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. All stock was regularly date checked and records kept. But on one section of shelving, the pharmacy had items which had passed their expiry dates. A 150g pack of Oilatum cream had expired in June 2019 and a pack of Granuflex dressings had expired in September 2019. However, staff said that these products were rarely supplied, and they would always check the date of expiry when dispensing. In addition, there was an original Consilient Health pack of quetiapine 25mg tablets which contained several mixed batches from other manufacturers; Milpharm, Teva and Accord, but not Consilient Health. And none of the strips in the pack contained an expiry date. The pharmacy had the equipment for scanning products with a unique barcode in accordance with European Falsified Medicines Directive (FMD) requirements. But was not yet scanning them.

Waste medicines were disposed of in the appropriate containers and collected by a licensed waste contractor. But staff did not have a list of hazardous waste to refer to, to help ensure that all waste medicines were disposed of appropriately. But it did have a separate container and separate disposal arrangements for cytotoxic medicines. Drug recalls and safety alerts were acted upon promptly. Records were kept for recalls of items which the pharmacy stocked. Although these were not available

to view in the pharmacy. None of the affected stock had been identified in the recent recalls for ranitidine tablets. But the pharmacy had identified stocks of Beconase nasal sprays from a recent recall. The nasal sprays had been removed from stock and set aside for return to the wholesaler.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy has the equipment and facilities it needs to provide services safely. And, it uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured into place in accordance with regulatory requirements. The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and generally clean. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to a range of up-to-date information sources such as hard copies and the on-line BNF and BNF for children. They also used the drug tariff, and the NPA advice line service and had access to a range of reputable online information sources such as the NHS, NICE and EMC.

The pharmacy had one computer in the dispensary and one on the counter. Both computers had a PMR facility. They were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal. Staff used their own smart cards when working on PMRs. They used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure.

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.