General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, The Bridge Shopping Centre, Somers Road North, PORTSMOUTH, Hampshire, PO1 1SL

Pharmacy reference: 1095383

Type of pharmacy: Community

Date of inspection: 14/08/2019

Pharmacy context

This Healthy Living Pharmacy (HLP) is located in a large ASDA supermarket close to the centre of Portsmouth. It dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy offers flu vaccinations in the autumn and winter seasons and can supply anti-malarial medicines for people who may need them when travelling abroad.

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	2.1	Good practice	There is evidence that staffing levels are continuously reviewed to provide assurance that they remain appropriate for the workload.
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 monitors and reviews the safety of its services to protect people and further improve patient safety. Its team members log and review the mistakes they make so that they can learn from them and act to avoid problems being repeated. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They understand their role in protecting vulnerable people, and they keep people's private information safe. The pharmacy has appropriate insurance to protect people if things do go wrong. It keeps the records it needs to by law. But it hasn't kept all of its records up to date and team members haven't always been recording things properly on their computer system. This will make it harder for them to tell exactly what happened if problems or queries arise in the future.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards, and all were available online to every member of staff. Each individual member of staff received a monthly notification of any new or updated SOPs for them to read and sign online. All staff communicated with each other to ensure that nobody missed any of the updates. There was a detailed business continuity plan in place dated April 18, to ensure that the pharmacy could maintain its services in the event of a power failure or other major problem.

Errors and near misses were recorded using a paper 'weekly near miss tracker' form, showing the date and time of the error, what the error was, the members of staff involved and the action taken. The tracker form also indicated the actual staffing hours available that week and the planned hours based upon the volume of work. These showed an increase in staffing hours, both planned and actual, from June onwards. The possible causes of the near misses were recorded and there was evidence of reflection and learning. The responsible pharmacist explained how she discussed near misses and errors with the individual(s) involved and with the team as a whole if she identified any consistent patterns or trends. There were also 'monthly safety review' forms which were used to collate the near misses for the month, to identify the possible causes and document the key learning points. This was completed together with the RPs line manager and discussed with the team. However, they had not been completed since Dec 18 and the pharmacist explained that she tended to do them in batches when she had time. She acknowledged that she needed to complete them and bring the file up to date. As a result of their reviews, they had identified some items that were prone to error, such as amitriptyline and amlodipine which had been highlighted with a yellow caution sticker on the shelf. The pharmacist explained that they received notifications of 'look alike sound alike' medicines (LASAs) from their head office but didn't find that their near misses related to the listed LASAs. They had separated the various strengths of quinine sulphate and bisulphate as these had been incorrectly selected in the past. Errors were recorded on the Pharmapod system. There was a separate dispensing incident folder for recording them, and also the 'pharmacy re-training sign off document' for each member of staff involved in an incident to show that they had re-read the relevant SOPs.

Roles and responsibilities of staff were set out on a matrix which was available online but could not be located at the time. However, those questioned were able to clearly explain what they do, what they

were responsible for and when they might seek help. They outlined their roles within the pharmacy and where responsibility lay for different activities.

Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist (RP) notice was clearly displayed for patients to see and the RP log held in a lever arch file was complete and correct.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were displayed online at www.nhs.uk. They showed 100% satisfaction ratings under most of the headings and an overall rating of 78.8% excellent or very good. Areas for improvement highlighted by the CPPQ included reviewing the layout of the pharmacy and reviewing the staffing rota to ensure that there were sufficient staff available at busy times of day. As a result of this feedback the pharmacy removed much of the clutter in front of the counter, replaced the main pharmacy signage and obtained a new display stand for 'safe & sound' products. The pharmacy complaints procedure was set out in a notice on display, and in the pharmacy practice leaflet. The notice also outlined the company's chaperone policy and data protection statement. A certificate of professional indemnity insurance valid until April 2020 was available online.

Private prescription records were maintained on the patient medication record (PMR) system and were complete with most details correctly recorded. However there were several entries where the correct prescriber had not been recorded, for example a private dental prescription recorded as being issued by a local GP. The RP agreed to brief the team and all locums to ensure that the correct details would be recorded in future. The emergency supply records were completed on the PMR system, and most were recorded as being made at prescriber request. These entries related to prescriptions faxed to the pharmacy from the local walk-in centre or from the GP out of hours service. Many had not been redeemed against a prescription and one supply that had been made at a patient's request had no reason recorded. The RP agreed to ensure that all staff, including locum pharmacists, will use this part of the PMR system correctly in future, and ensure that all details will be fully recorded. She would also ensure that as soon as the prescriptions were received, they would be redeemed against the entries on the PMR system and any missing prescriptions followed up with the prescriber.

The CD registers were correctly maintained, with running balances checked at regular weekly intervals every Saturday. The SOP referred to a weekly balance check. All pages had the headers completed in full, but some of the wholesaler's addresses had not been included. This was discussed, and the pharmacist said that she would record the address shown on the invoices in future. Running balances of two randomly selected CDs were checked and both found to be correct. Alterations made in the CD register were asterisked with a note made at the bottom of the page, and they were initialled with the pharmacist's registration number and date. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed "specials" were all complete with the prescriber details.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They were able to provide examples of how they protect patient confidentiality, for example ensuring that no paperwork was left on the counter and inviting people into the consulting room when discussing sensitive information. Completed prescriptions in the prescription retrieval system were out of sight of people waiting at the counter. Confidential waste was kept separate from general waste and shredded onsite. Confidentiality agreements had been signed annually by everyone with access to the pharmacy.

There were safeguarding procedures in place and contact details of local referring agencies were available to the pharmacist on the NHS safeguarding app. The pharmacist explained that there was

usually a notice with those contact details on display in the dispensary, but it had recently disappeared. The pharmacist had completed level 2 safeguarding training, and the rest of the team had completed ASDA safeguarding training. They understood the signs to look out for and would refer any concerns to the pharmacist. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy continually monitors its staffing levels and ensures that it has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a good understanding of their roles and responsibilities. They can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There were two trained medicines counter assistant (MCA), and the RP on duty during the inspection. This appeared to be appropriate for the workload and everyone was working well together. In the event of staff shortages, other team members would increase their hours, or the pharmacist could call upon the Saturday staff to help where possible. There were also some trained staff in the supermarket who could cover the pharmacy if necessary. Overall staffing levels were recorded on the weekly near miss tracker form and compared with the planned hours based upon the workload.

Training records were seen confirming that all staff had completed the required training, and there were some certificates on display in the consulting room. Each member of staff was able to access various training modules from the ASDA 'Healthcare Learning Online' (HeLO) system. There was also a separate learning management system available for managers and pharmacists. Staff were able to demonstrate an awareness of potential medicines abuse and could identify people making repeat purchases. They described how they would refer to the pharmacist if necessary.

The dispensers and pharmacist were seen to serve customers and all were asking appropriate questions when responding to requests or selling medicines. The pharmacist confirmed that she was comfortable with making decisions and did not feel pressurised to compromise her professional judgement. Team members were involved in open discussions about their mistakes and learning from them. Team members said that they could raise concerns and although they weren't sure about a whistleblowing policy, they knew who to contact if they needed to. There were targets in place, but they were applied reasonably and did not impact upon the professional judgement of the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive its services

Inspector's evidence

The pharmacy was located adjacent to the main entrance to the supermarket. The premises were clean, tidy and in a good state of repair with step-free access. There was a long rectangular dispensary, providing plenty of space to work safely and effectively, and the layout was suitable for the activities undertaken. The workbenches were clean and clear of clutter with a clear workflow through the dispensary. The dispensary sink had hot and cold running water, although both taps were loose in their fittings. There was handwash and a paper towel dispenser available. There was a low height gate to prevent unauthorised access to the pharmacy medicines on display. There were also roller shutters to secure the dispensary and medicines counter area from the remainder of the premises when the pharmacy was closed. The main shutter was raised all the time the supermarket was open, but the pharmacy was still secured by separate shutters across the pharmacy medicines display and across the entrance to the dispensary. The consultation room was locked when the pharmacy was closed, and night staff did not have access to the pharmacy area.

There was a consultation room available for confidential conversations, consultations and the provision of services. The door to the consultation room was kept locked when the room was not in use. There was a sink with hot and cold running water, a portable hearing loop, a sharps container and a password-protected PMR terminal in the room.

There was a separate staffroom, and the toilet areas were clean and well maintained by the supermarket cleaners. Room temperatures were appropriately maintained by a combined heating and air-conditioning unit, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages medicines safely, and so makes sure that all of the medicines it supplies are fit for purpose. The pharmacy responds appropriately to drug alerts or product recalls so that people only get medicines or devices which are safe. Team members take steps to identify most people supplied with high-risk medicines so that they can be given extra information they need to take their medicines safely. But they don't always record those checks. This may make it harder for them to show what they have done if any queries arise in the future.

Inspector's evidence

A list of pharmacy services was displayed adjacent to the pharmacy and there was also a range of health information leaflets in a display stand at the prescription reception counter. The pharmacy provided a limited range of services including seasonal flu vaccinations during the autumn and winter.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting those medicines considered to be vulnerable to mis-picks. They used colour-coded baskets to keep individual prescriptions separate, and to highlight those waiting for collection and those sent electronically. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were in use when medicines could not be supplied in their entirety. Patients were referred back to their GP or another pharmacy if the pharmacy was unable to obtain their medicine.

Completed prescriptions for CDs were highlighted with a CD sticker so that staff would know that they needed to look for a bag in the CD cupboard. Schedule 3 CDs were also stickered and the prescription annotated with a prompt to remind staff to record the date it was collected by the patient. Schedule 4 CDs were not highlighted so the pharmacist agreed to find ways of reducing the risk that they may be handed out after the prescriptions had expired. She explained that they cleared the retrieval shelves approximately every eight weeks and that any expired Schedule 4 CDs still awaiting collection were removed. Fridge lines in retrieval awaiting collection were highlighted so that staff would know that there were items to be collected from the fridge.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled and provided with leaflets and cards highlighting the importance of having effective contraception. The valproate audit identified nobody in the at-risk group. Patients on warfarin were asked if they knew their current dosage, and whether their INR levels had been recently checked. These interventions were not recorded and the figures themselves were not routinely asked for. Upon reflection the pharmacist and the dispensers all agreed that they would start asking for this information and recording the intervention on their PMR system. Patients taking methotrexate and lithium were not routinely asked about blood tests. The PGD for the seasonal influenza vaccination service expired at the end of the season in March 2019. Records were seen of consent and vaccinations provided, for both the private and the NHS services. The PGD relating to the supply of atovaquone/proguanil for the chemoprophylaxis of malaria was valid and had been signed in February 2019.

Medicines were obtained from licensed wholesalers including AAH and Alliance. Unlicensed "specials"

were obtained from AAH or from Alliance specials. The pharmacy was complying with the Falsified Medicines Directive (FMD) and scanning those products with the appropriate 2-D barcode. They underlined the patient name on the bag labels to indicate the need for them to scan the label when handing the prescription to the patient in order to complete the decommissioning process.

Routine date checks were seen to be in place, and record sheets were seen to have been completed. Stock with a shelf life of less than six months was recorded and then disposed of upon expiry. The pharmacy completed a weekly compliance form, verifying that they had complied with data protection procedures, completed patient safety reports, completed the RP log and undertaken the CD stock balance checks. These forms were then audited around the 7th of every month by the store administration manager, who also conduct other random checks at the same time. Opened bottles of liquid medicine were annotated with the date of opening, and there were no plain cartons of stock seen on the shelves. No boxes were found to contain mixed batches of tablets or capsules

Fridge temperatures were recorded daily on a weekly monitoring form, and all seen to be within the 2 to 8 Celsius range. The RP would sign the weekly form at the end of each week. Staff explained how they would note any variation from this and check the temperature again every 30-60 mins until it was back within the required range. Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. There was a list of hazardous medicines and a separate purple-lidded hazardous waste container present. Patients with sharps were signposted to the local council for disposal. Denaturing kits for the safe disposal of CDs were available for use. The pharmacy received drug alerts and recalls from the MHRA and via emails from ASDA head office. Each alert was annotated with any actions taken, the date and initials of those involved and then the files were returned to the store office for filing. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides, and it keeps people's private information safe.

Inspector's evidence

The pharmacy had the necessary resources required for the services provided, including the consulting room itself, a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics), reference sources including the BNF and BNF for children. The pharmacy also had internet access and used this as an additional reference source.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens are positioned so they are not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen to be used appropriately and with no sharing of passwords. They were not left on the premises overnight. Confidential information was kept secure and items awaiting collection were not visible from retail area

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.