General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, South Church Road, BISHOP AUCKLAND, County Durham, DL14 7LB

Pharmacy reference: 1104084

Type of pharmacy: Community

Date of inspection: 16/02/2023

Pharmacy context

The pharmacy is in an Asda supermarket in Bishop Auckland. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including the NHS Community Pharmacist Consultation Service (CPCS). And they provide medicines to people in multi-compartment compliance packs.

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 adequately identifies and manages risks to its services. And it has documented procedures to help it provide its services effectively. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members mostly record and discuss the mistakes they make to learn from them. But they don't always capture enough key information in these records to help aid future reflection and learning.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. These were available to team members on the company's online training platform. Pharmacy team members received new and updated SOPs each month to read via the training portal. Each procedure was accompanied by an assessment to test people's understanding. Pharmacy team members confirmed their understanding by passing the assessment. Pharmacy team members were clear about where the procedures were kept if they needed to refer to them. The responsible pharmacist (RP) explained the system would inform them via email if someone was unable to pass an assessment, so they could provide the person with further training and support.

The pharmacy provided the NHS Community Pharmacist Consultation Service (CPCS) to people. People were referred to the pharmacy for help, most usually after contacting NHS111 or after being triaged by the GP surgery. The pharmacy then helped people by providing appropriate face-to-face care or by referring people further for more specialist help. The pharmacy had good working relationships with local GPs. And this meant they could easily refer people for an appointment, if necessary, after being seen by the pharmacist. This included good access to GPs out of hours, to coincide with the pharmacy's extended opening hours. The pharmacy had considered the risks of delivering the CPCS to people. The pharmacist explained how the team had assessed various risks, such as the suitability of the pharmacy's consultation room to deliver the service from, ensuring that people had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made. There were documented procedures to help them do this effectively. They used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as quetiapine and quinine, to help prevent the wrong medicines being selected. The records available contained little or no information about why mistakes had been made. Or the changes team members had made to prevent them happening again. Pharmacy team members had also not recorded any near miss errors in December 2022. And few records had been made in January 2023, although records were available before and after these months. The RP explained that the pharmacy had been very busy in December and January, and they admitted that mistakes had been made that were not recorded. A dispenser confirmed that although errors had not been recorded, they had still discussed their mistakes and made changes where necessary to help prevent them happening again. The pharmacist looked at the data collected each month to establish any patterns of errors. And they discussed the patterns found with the team. They recorded their analyses, but they did not analyse the data to establish any patterns of

cause. This meant they might miss opportunities to reflect, learn, and make improvements to the pharmacy's services. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. The sample of records seen were comprehensive and gave detailed information about the causes of errors, and the changes the team had made to help prevent the same or similar error happening again.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. And it had materials available for people in the retail area about how to provide feedback. Pharmacy team members explained feedback was usually collected verbally and by using yearly questionnaires given to people at the pharmacy counter. Team members could not provide any examples of any changes they had made in response to people's feedback. The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained a responsible pharmacist record, which was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. They explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the team members present were the pharmacist manager and three qualified dispensers. And they were observed to manage the workload well. Team members completed mandatory e-learning modules regularly. Their latest modules included training on sepsis, safeguarding and weight management. And they also regularly discussed learning topics informally with each other. Team members regularly read new and revised standard operating procedures (SOPs) via the company's online training platform. And were required to pass a short test after reading each SOP to confirm their understanding. The pharmacy had an appraisal process in place for pharmacy team members. But team members could not remember when they had last received an appraisal with their manager. They explained how they would address any learning needs informally with either of the pharmacy's managers, who would help them by providing training or signposting them to appropriate resources.

Pharmacy team members explained they would usually raise professional concerns with their pharmacists or healthcare manager. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. One recent example was the team changing how various areas of the pharmacy were organised. This had helped to make various areas easier to access, such as various areas of the shelves where medicines were kept. And the area where prescriptions were stored once they had been dispensed. The team explained this had helped to make the dispensing process more efficient and safer by helping to prevent mistakes. Pharmacy team members communicated openly during the inspection. They were asked to achieved targets in various areas of the business, for example the number of prescription items dispensed, and the number of services being delivered. Team members explained they felt comfortable achieving the targets set, which were monitored by the pharmacy's healthcare manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides, which it properly secures when the pharmacy is closed. And it has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet elsewhere in the store, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally supplies medicines to people safely. It sources and manages its medicines well. The pharmacy has suitable processes in place to help people manage the risks of taking high-risk medicines. But it does not always provide people with the necessary printed information to help them manage these risks and take their medicines safely.

Inspector's evidence

The pharmacy had level access from the supermarket car park through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. Pharmacy team members also attached a sticker to prescription bags containing CDs. They wrote the expiry date of the prescription on the sticker. This was to help prevent the medicines being given out after the prescription had expired. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. Team members were currently completing an audit of people who received valproate from the pharmacy. They intended to use the information collected to help make sure that all at risk patients had been properly identified and provided with the right information.

The pharmacy supplied medicines for people in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines when they were first prescribed. But they did not routinely provide people with leaflets after that. Pharmacy team members documented any changes to medicines provided in packs on the person’s master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR).

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy’s fridge each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items during the month before their expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They

removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.