General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Honey End Lane, READING, RG30 4EL

Pharmacy reference: 1115956

Type of pharmacy: Community

Date of inspection: 20/07/2022

Pharmacy context

This is a community pharmacy within a large supermarket. The supermarket is in on the edge of Reading town centre The pharmacy provides a range of services including dispensing prescriptions. And it has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a blood pressure measuring service and a flu vaccination service in winter.

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	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 suitable procedures to identify and manage risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team keeps people's private information safe. And it knows how to protect the safety of vulnerable people.

Inspector's evidence

The team had a system for recording its mistakes. And it reviewed them every week and again every month. The responsible pharmacist (RP) was one of two regular full-time pharmacists. And she had worked at the pharmacy for several months. She described how she and her pharmacist colleagues highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. This enabled them to reflect and learn. The RP recognised the importance of monitoring and reviewing near misses and errors so that the team could learn as much as possible from them. And she agreed that weekly records should reflect what the team member had learned and what they could do differently next time to prevent mistakes and promote continued improvement. When carrying out the monthly reviews pharmacists looked at any mistakes which had recurred since the last monthly review. And they identified common errors and ways to prevent them. The team had identified common errors between medicines which were available as tablets and capsules and had discussed the risk of selecting the wrong one. The team had also placed a list of the 'most commonly prescribed drugs for patient safety incidents' on its notice board to alert the staff to the potential for error. And it had reminder notices on display about the risk of error between gabapentin and pregabalin. And look-alike sound-alike medicines such as amlodipine, amitriptyline, atenolol and allopurinol. These lists were available to remind staff to check that they had selected the right one.

The pharmacy had put measures in place to keep people safe from the transfer of infections. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points daily. The pharmacy had hand sanitiser for the team to use. It had put screens up at its medicines counter. And its team members wore masks. The pharmacy had reduced its range of services during the pandemic. It had done this in part because of a lack of demand and also to concentrate on delivering a safe dispensing service. But since restrictions had lifted it had been able to offer more of its other services. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were up to date. And team members had read the SOPs relevant to their roles. They understood their roles and responsibilities and consulted the pharmacists when they needed their advice and expertise. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback to the store management team or to the superintendent's office. Recent customer comments indicated that many people were unhappy if the pharmacy did not have their medicines in stock, especially where they had a preference for a particular brand. In response, the team ensured that it reordered at least one pack of the tablets for the next instalment as soon as possible after it had supplied the last ones. When the tablets came in the team banded the product with a label showing the person's name. They did this to make sure they did not dispense it for anyone else. The RP demonstrated this for particular brands of levothyroxine and carbocisteine. The

pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But pharmacists generally dealt with people's concerns at the time. The store management team could also deal with people's concerns when appropriate. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register and its RP record. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacist could not locate any emergency supply records. But she could not recall making any emergency supplies in recent times. This was due to them being able to supply medicines in an emergency under its community pharmacy consultation service (CPCS). The pharmacy kept records of its private prescriptions electronically. But several records did not show the prescriber's address. The pharmacy had a CD destruction register for patient-returned medicines. The regular pharmacist agreed that it was important to ensure that the record was up to date with all destructions recorded at the time. The inspector and pharmacist discussed the importance of ensuring that the pharmacy's records were accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They discarded confidential paper waste into separate waste bins. And they shredded confidential paper waste as they worked. The team kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to one of the pharmacists. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. And the pharmacy had one of its regular pharmacists on duty. The pharmacist worked alongside two dispensing assistants. One of which worked on the counter during the inspection. A further trainee dispensing assistant arrived part-way through the inspection. Overall, team members were seen to work effectively with one another. And they supported one another to complete their tasks. The pharmacy had a small close-knit team of mostly part-time staff who worked regularly together. They kept the daily workload of prescriptions in hand and they attended to customers promptly. Pharmacists were able to make day-to-day professional decisions in the interest of patients. The RP explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. And it had also had staff shortages. But its team members covered extra shifts to help out. And the pharmacy had not had any unplanned closures. The RP described how team members treated people and each other with respect

Team members could discuss their concerns with their line managers. And they felt supported in their work. They had regular reviews about their work performance. And they kept their knowledge up to date through the Asda online e-learning training modules (Halo). Pharmacists could make their own professional decisions in the interest of people and did not feel under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made sensible adjustments to help reduce the risk of the spread of viral infections. And its workspace is tidy and organised.

Inspector's evidence

The pharmacy was on the back wall of the store. It had a long counter and a small waiting area. The counter had a lower height area at one end for wheelchair users and others to use. It kept its pharmacy medicines behind the counter. And people could also hand in or collect their prescriptions here. The pharmacy had a doorway from the counter area into the dispensary behind. And it had measures in place to prevent unauthorised access after the pharmacy had closed.

The dispensary had three full-height walls around it. This provided an area for team members to work with fewer interruptions. The dispensary had a workbench along one side. And storage drawers and shelves on its other walls. Workbenches also had storage areas above and below. And they were tidy and free of clutter. The pharmacy stored its dispensed items and prescriptions so that people’s information was out of view. The pharmacy also had a consultation room. The consultation room had an entrance from the customer area next to the counter and one from the dispensary. The team kept the consultation room locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And it has appropriate procedures to ensure that it supplies its services safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly

Inspector's evidence

The pharmacy was well signposted both outside and inside the store. The store had a wide automatic door which provided step-free entry. And the route to the pharmacy and the area around the pharmacy counter was free of clutter, making it suitable for people with mobility issues to use. The pharmacy could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy also supplied medicines against private prescriptions, some of which came from its online prescribing service.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And pharmacists would explain to people how to use their compliance packs when they first started having their medicines this way. The RP described how they would also assess people's needs before giving them a compliance pack. They did this to ensure that a compliance pack was suitable for them. The pharmacy managed the service according to a four-week rota. And it checked and verified any changes to prescriptions every month. And people's records updated. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people had the information they needed about their medicines. The pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate and steroid medicines. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP knew about the precautions she would need to take, and counselling she would give, if the pharmacy was to supply it to someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And its stock was tidy and organised. It generally stored its medicines appropriately and in their original containers. The RP and inspector agreed that team members should ensure that they store medicines in their original packaging where possible. This was so that medicines' packaging contained all the right information. And to provide assurance about each medicine's identity and quality. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the inspector was in date. Team members identified and highlighted short-dated stock. And they put the pharmacy's out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that it kept the medication inside

within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. Its equipment was clean. The pharmacy had just obtained a new blood-pressure monitor for its blood pressure screening service. And it would replace the monitor for a new one every year. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room, on the counter and in the dispensary. Computers were password protected. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.