General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, 1 Alexander Grove, London Road, SWANLEY, Kent, BR8 7UN

Pharmacy reference: 1116105

Type of pharmacy: Community

Date of inspection: 19/05/2023

Pharmacy context

The pharmacy is in a superstore in Swanley town centre and it receives most of its prescriptions electronically. It provides NHS dispensing services and the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 not all met	2.1	Standard not met	The pharmacy does not have enough staff to keep up to date with its workload.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not keep its premises tidy and free from tripping hazards. And its work surfaces are cluttered which only leaves it with very limited space for dispensing.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have enough fridge space to always store its medicines requiring cold storage properly. And it does not always store its controlled drugs securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is currently under some staffing pressure and there have been closures of some local pharmacies, which had increased the team's workload. And the pharmacy's premises are cluttered. However, the team members are otherwise doing what they can to manage the risks. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people. But it doesn't always record mistakes that happen during the dispensing process. So team members may be missing out on opportunities to learn and improve the safety of the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members said that there had been several recent near misses, where a dispensing mistake was identified before the medicine had reached a person. But these had not been recorded. They explained that near misses were discussed briefly at the time and rectified. There had been several recent dispensing errors, where a dispensing mistake had reached a person. Team members said that the regular pharmacist was in the process of investigating them, and they would complete an incident report form. A recent error had occurred where the wrong type of medicine had been supplied to a person. The medicine and prescription had been put to one side for the regular pharmacist to investigate what had happened.

Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would not open if the pharmacist had not turned up in the morning. And she would contact the pharmacy's head office to inform them. She knew which tasks she should not undertake if there was no responsible pharmacist (RP) signed in. And she would not hand out any dispensed items or sell any pharmacy-only medicines if the pharmacist was not in the pharmacy.

Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not always recorded. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The private prescription records were completed correctly. And the nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Team members said that most of the recent complaints had been about the pharmacy's waiting times, stock availability and prescriptions not being ready to collect.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She said that there had not been any recent safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough team members to keep up with its dispensing and other routine tasks including stock audits. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members had access to ongoing training, but they do not get time at work to complete it. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

There was one locum pharmacist, one trainee dispenser and one team member who had started working at the pharmacy at the beginning of the week. The trainee dispenser had been enrolled on a suitable course for her role, but her training had been put on hold due to the pharmacy's workload. She explained that the pharmacy had been in the process of recruiting more staff, but the pharmacy was still behind on several tasks. Such as, balance checks and stock management. Another team member arrived at the pharmacy shortly after the inspection started. She said that she was a trained medicines counter assistant (MCA) and had been undertaking dispensing tasks for around two months. She said that she was due to be enrolled on a course and the inspector reminded her of the timeframe for this. A team member explained that the pharmacy had been short staffed for around one year. And the workload had doubled in that time due to local pharmacy closures. The pharmacy's regular pharmacist had left a few months ago. And the team was currently around four days behind on dispensing prescriptions. During the inspection there were queues of people seen waiting at the pharmacy counter.

Team members appeared confident when speaking with people. The newest member of the team referred queries to other team members throughout the inspection. And she said that she would always refer to the pharmacist if a person asked to purchase an over-the-counter medicine. She checked which questions should be asked and passed on the information to the pharmacist before making the sale. Team members knew which medicines which could be abused or may require additional care. A team member explained how the pharmacy had intervened when a person had been over-prescribed a medicine and the person's GP had been contacted.

Team members said that training had been put on hold due to the workload. Team members said that they should have one hour protected training time each week, but this has not been happening. And team members had been completing ongoing training received from head office in their own time. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. One team member said that targets were set for the New Medicine Service, but the chart was not on the wall in its usual place. She said that the pharmacist would usually deal with any targets, and she was not sure if the pharmacy was meeting them.

One team member said that there were no regular team meetings and information was usually passed on during the day or put it the pharmacy's messaging group. Team members had not had their usual performance reviews or appraisals recently. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not keep its premises tidy and free from tripping hazards. And it only has very limited space available for dispensing. The consultation room is being used for storage, which could limit the opportunities people have to speak with a team member in a more private area. The premises are secure from unauthorised access.

Inspector's evidence

Team members said that the pharmacy was due to have a refit. The pharmacy's consultation room was being used for storage and had temporary shelves which had bagged items awaiting collection. The room was not currently being used for consultations. Team members said that if someone wanted to use the room then shelves could be moved, but there was not enough space in the dispensary to be able to store them. Team members said that enhanced NHS services had been put on hold due to the consultation room not being easily useable.

Floor space in the dispensary was limited due to delivery boxes and these presented tripping hazards. The boxes contained medicines delivered the day before the inspection. The pharmacy received another delivery during the inspection which meant that there was even less floor space available. Team members said that they struggled to find time to put the deliveries away due to the workload. This also meant that team members were having to spend time looking through the boxes when people arrived to collect their medicines that had been ordered the previous day.

Most of the work space was cluttered and there were medicines in baskets piled in corners of the work tops. Team members dispensed in a small area next to the computer screen and the pharmacist checked medicines in a small area on the other side of the computer screen. Team members said that some of the dispensing mistakes were due to items being dispensed where people using the pharmacy could interact with them, and this increased the number of distractions. There were plans to install a second computer screen in an area to the rear of the dispensary so that this could be used for dispensing.

The pharmacy was secured from unauthorised access and pharmacy-only medicines were kept behind the counter. Two of the shutters covering these medicines were broken and not able to be opened. Team members said that they could sometimes reach around the shutter to reach medicines, but often people had to be signposted to another pharmacy. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines. There were two chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Toilet facilities were available in the store area.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store its medicines properly. It does not have enough fridge space to always store its medicines requiring cold storage. And it does not always store its controlled drugs securely. However, the pharmacy otherwise provides its services in a generally safe way. The pharmacy gets its medicines from reputable suppliers. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. And the pharmacy dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access through the store area and up to the pharmacy counter. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And the pharmacy could produce dispensing labels with a larger print for those who needed them.

Some CDs that people had returned for destruction were not kept secure. The pharmacist said that she would remind team members about the process of receiving returned medicines from people. Other returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The pharmacy's other CDs were largely stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs kept in the CD cabinet were clearly marked and kept separated from dispensing stock.

Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines, but it was overstocked. Team members said that the fridge was usually this full. This made it harder for team members to find items quickly. Some fridge items arrived during the inspection. A team member managed to make enough room for some of the items, but there was no room for some other medicines which required refrigeration. To try and solve the issue, team members were checking how long the medicines could remain out of the fridge for and were attempting to contact the person they were for to arrange collection. Stock in the dispensary was not stored in an organised manner. There were different medicines and strengths mixed up, which could increase the risk of a picking error. The trainee dispenser said that she thought the pharmacy was not up to date with its date checking. She explained that this was usually done over the weekend, but the chart was not in its usual place so she could not check. She said that she removed expired items if she found them while looking for a medicine to dispense. There were no expired items found with dispensing stock during a random spot check.

Dispensed fridge items were kept in clear plastic bags to aid identification. Team members checked CDs and fridge items with people when handing them out. The pharmacist said that she would refer a person to their GP if they were taking a valproate medicine and were not on the Pregnancy Prevention Programme (PPP) when they needed to be on one. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the PPP. The pharmacy had the relevant patient information leaflets or warning cards available and warning sticker for use with split packs. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was

not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 CDs were highlighted but those for Schedule 4 CDs weren't. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The trainee dispenser said that she would ask for a list of these medicines so that team members could highlight these in future during the dispensing process.

The trainee dispenser said that uncollected prescriptions were checked regularly. A text messaging system was available, but it had not been used for a while. She said that this was starting to be used again so that people would be sent a message to remind them that they had items to collect. Items waiting collection were kept on shelves in the consultation room. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The trainee dispenser was not sure if people had had assessments carried out to show that they needed their medicines in multi-compartment compliance packs. The pharmacy was not taking on any additional prescriptions for people needing their medicines in these packs. A team member said that people would be referred to another local pharmacy or to their GP. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The trainee dispenser said that the pharmacy contacted people to see if they needed their 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The trainee dispenser explained the action the pharmacy took in response to any alerts or recalls. There were some kept in a folder in the pharmacy, but team members did not know where the ones for 2023 were kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. And it uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.