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: 15/01/2024

Pharmacy context

The pharmacy is in a busy shopping precinct in Swanley town centre. It provides NHS dispensing services, the New Medicine Service, and it supplies flu vaccinations and contraceptives against Patient Group Directions (PGDs). And a hypertension case-finding service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

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 generally identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information well. And people can provide feedback about the pharmacy. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. One of the dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. The team would attempt to contact the pharmacist and head office would be informed if needed. Team members knew what they could and shouldn't do if the pharmacist was not in the pharmacy.

Team members explained how the pharmacy dealt with near misses, where dispensing mistakes were identified before the medicines had reached a person. These were highlighted with the team member involved at the time of the incident. And once the mistakes were highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. A suggestion since the most recent review was to better organise the inhalers. And there had been no near misses involving the selection of the wrong inhaler since. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of a medicine had been supplied to a person. The person was supplied with the correct medicine and the pharmacy's head office had been informed.

There were separate work areas designated for different tasks such as dispensing and checking. And an organised workflow helped team members prioritise tasks and manage the workload. Workspace in the dispensary was free from clutter and baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were a few private prescriptions found during a spot check that did not have the required information on them when the supply was made. The pharmacist said that she would remind team members to check that a prescription was legally valid at the time of supply. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that she would remind team members to record this information in future. There were signed in-date patient group directions available for the relevant

services offered.

Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But the pharmacist had filled in parts of the record in advance. She said that she would complete it contemporaneously in future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and 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. People's personal information on 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. The pharmacist said that there had not been any recent complaints. She explained that she would attempt to deal with any complaints and inform the pharmacy's head office. She also mentioned that the pharmacy's head office would ask the pharmacy to investigate any complaints it received about the pharmacy directly.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undergone some safeguarding training provided by the pharmacy's head office. The trainee dispenser knew which people might be classed as vulnerable and could describe potential signs that might indicate a safeguarding concern. She said that she would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And the trainee dispenser said there had been no safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members do the right training for their roles. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. And there are enough team members to provide the pharmacy's services safely. Team members can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets. They can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist, two trained dispensers and a trainee dispenser working during the inspection. Team members had either completed an accredited course for their role or they were enrolled on one. They wore smart uniforms with name badges displaying their role. And they worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. This helped the pharmacy to keep up to date with its dispensing and other tasks.

Team members appeared confident when speaking with people. They would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And they knew the restrictions on sales of medicines containing pseudoephedrine. Team members asked questions to establish whether an over-the-counter medicine was suitable for the person it was intended for.

The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. She felt able to make professional decisions and she was aware of the continuing professional development requirement for revalidation. She said that she had recently completed some online refresher training for the flu vaccination service, and she was in the process of completing the necessary training for the Pharmacy First service. She had also done the necessary training for the contraception service. The pharmacist said that team members were not provided with regular ongoing training on a regular basis, but they did receive some. Team members could access training modules online either in the pharmacy or at home. And they could complete the mandatory training, such as reading updated SOPS, in the pharmacy during quieter times.

Team members said that there were no regular meetings, but they passed on information informally throughout the day. And a messaging service was used to share important information with the whole team. The pharmacist joined a weekly conference call with other pharmacies in the area and the area manager. She said that any issues were discussed during the meetings, and she had the opportunity to provide feedback. Targets for the New Medicine Service were also discussed during the meetings. The pharmacist explained that she did not feel under pressure to achieve the targets. She provided the service for the benefit of the people using it and would not let the targets affect her professional judgement.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And the pharmacist said that she could contact the pharmacy's customer training manager or area manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access and pharmacy -only medicines were kept behind the counter. It was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities were available in the main store and there were separate hand washing facilities available.

There were several chairs in the area in front of the pharmacy. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being overheard. The consultation room was accessible to wheelchair users, and it could be accessed from the main store area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. There was a spy hole in the door to the shop area so that staff could check that the area was clear before opening the door outwards.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. The pharmacy highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access into the store and the pharmacy was near the main entrance. 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 large-print labels for people who needed them. Notices were displayed at the counter informing people about the times the pharmacy was due to be closed during the day.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept which made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted which helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said team members checked CDs and fridge items with people when handing them out. Team members said that 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 Pregnancy Prevention Programme (PPP). The pharmacist said that people would be referred to their GP if they needed to be on the PPP and weren't.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference and reported to the pharmacy's head office. This made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were clearly marked with the month and year of expiry. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

CDs requiring safe storage were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. And CDs that people had returned and expired CDs were clearly marked and kept separated from dispensing stock. CDs returned by people were recorded in a register at the time of receipt. Records showed that these were destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

Team members said that uncollected prescriptions were checked regularly, and people were contacted if they had not collected their items after around six weeks. 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 daily, and the suppliers were contacted to check stock availability. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

People had assessments to confirm that they needed their medicines in multi-compartment compliance packs. There were no assembled packs available on the day of the inspection but one of the dispensers explained the processes for managing and assembling them. 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. Prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The dispenser said that people usually requested prescriptions for these medicines if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Based on the information provided, the packs appeared to be suitably labelled and there would be an audit trail to show who had dispensed and checked each pack. The dispenser said that medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. And she said that team members wore gloves when handling medicines that were placed in these packs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than one year. The pharmacy’s head office would replace it in line with the manufacturer’s guidance. The weighing scales were in good working order. 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.