General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Asda Superstore, Barwell Lane, HINCKLEY, Leicestershire, LE10 1SS

Pharmacy reference: 1034003

Type of pharmacy: Community

Date of inspection: 11/07/2024

Pharmacy context

The pharmacy is situated in an Asda supermarket. The pharmacy dispenses NHS and private prescriptions and sells medicines over the counter. It provides NHS services such as the 'Pharmacy First' service, the Hypertension case-finding service and Contraception service.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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	Good practice	1.1	Good practice	The pharmacy assesses and manages the risks when introducing new services.
		1.2	Good practice	Members of the pharmacy team record and review their mistakes and can demonstrate that they use these events to improve the safety and quality of the services they provide.
2. Staff	Standards met	2.4	Good practice	The pharmacy has a culture of openness, honesty, and learning.
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 ✔ Good practice

Summary findings

The pharmacy assesses and manages the risks when introducing new services. Members of the pharmacy team record and review their mistakes and can demonstrate that they use these events to improve the safety and quality of the services they provide. Its team members have defined roles and accountabilities. The pharmacy manages people's personal information safely.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) which had been signed by the pharmacy team members to show they had read and understood them. Staff were seen following the SOPs which included dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely and had a good understanding of the advice to give during a sale. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. The pharmacy highlighted CDs to remind the person handing the medicine out, of the shorter validity of these prescriptions. And regularly checked their electronic system for prescriptions that were going out of date.

Roles and responsibilities of the team members were identified in the SOPs. They wore uniforms and were easily identifiable with name badges. The Responsible Pharmacist (RP) notice was visible from the public counter but identified the previous pharmacist on duty. The pharmacist changed the notice to display the correct RP.

The pharmacy was providing the NHS 'Pharmacy First' services, hypertension case-finding service, and contraceptive service. The pharmacist explained that the pharmacy had considered the risk of the services impacting on their busy dispensing service. They used the rest of the pharmacy team to carry out an initial assessment to see if people were eligible for the 'Pharmacy First' service. They encouraged people, if possible, to visit the pharmacy when there were two pharmacists present. And they ran a blood pressure monitoring service on a designated morning (Thursdays).

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. Different members of the team completed a short weekly summary of incidents and then the pharmacist completed a monthly review which highlighted actions going forward. And, when asked, the pharmacy team members were able to recall the actions from the latest review and how these reduced the risk of a mistake being made.

The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the RP record, the private prescription book, and the CD register. The pharmacist had noticed how private prescriptions for CDs were not always being sent to the NHS business authority at the end of the month and had introduced a new process to make sure that they were. The entries for two items in the CD register checked at random during the inspection agreed with the physical stock held. Balance checks were completed weekly. Patient-returned CDs were recorded in a designated register and destroyed promptly on receipt.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential information was stored and destroyed securely. Professional indemnity insurance was in place. The pharmacy understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person. And they knew what to do if someone ‘asked for Ani.’

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a culture of openness, honesty, and learning. The pharmacy's team members manage the workload within the pharmacy well. They are suitably trained for the roles they undertake. And they can raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively and also kept clinical governance up to date. There were two pharmacists for most of the inspection, and four trained dispensers. There was a friendly culture within the pharmacy. The team members actively engaged with the inspection, they demonstrated their enthusiasm for the roles they undertook, their support for each other, and commitment to providing a good service. Staff said they felt supported by the manager and the pharmacist. They discussed any issues informally on a daily basis and felt able to raise concerns if necessary. Team members were observed referring queries to the pharmacist when needed. The team had access to online training and were also given ad hoc informal training from the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a private conversation in the consultation room.

Inspector's evidence

The public area in front of the pharmacy counter was small and during the inspection there was often a queue of people using the pharmacy's services. This made it more difficult to maintain confidentiality. The pharmacy team members were aware of the issue and said they were proactive in offering the consultation room. The dispensary was a little small for the services provided. The premises were clean, tidy and were well-lit. There was air conditioning to maintain a suitable temperature for storing medicines. Hot and cold running water was available. One reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy's team shows care and concern for people using its services. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy was situated in a supermarket which provided good access for people with a disability or a pushchair to get to the pharmacy. The whole pharmacy team showed a people focus and were heard engaging with people, looking to answer questions and resolve problems they had. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. Pharmacy medicines were stored out of reach of the public and staff were aware of higher-risk, over-the-counter medicines such as painkillers containing codeine. The pharmacy team knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate and had implemented the latest advice. The pharmacist gave a range of advice to people using the pharmacy's services. This included advice when they had a new medicine or if their dose changed or if medicines required ongoing monitoring such as methotrexate or warfarin.

The pharmacy was providing the NHS 'Pharmacy First' services. This allowed the pharmacy to treat seven common conditions including supplying prescription-only medicines. The pharmacist said that this service was being regularly accessed. Both regular pharmacists had completed the required training and had signed the accompanying patient group directions (PGDs). The pharmacy was proactively offering the hypertension case-finding service; stickers were placed on prescriptions so that team members handing out prescriptions knew who to speak to. The pharmacist said that they had found people with undiagnosed hypertension who had been prescribed medicines for hypertension when referred to their GP. The pharmacy team members said they had received positive feedback about these services.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to a small number of people living in the community to help them take their medicines at the right time.

Medicines were stored on shelves in their original containers. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. Medicines in the fridges were kept neatly and tidily in baskets. The pharmacy team had a process for date checking medicines. A check of a small number of medicines did not find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacy manager explained the process for managing drug alerts which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been last tested in September 2023. They looked in a reasonable condition. The pharmacist said he would speak to head office about having them tested.

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.