General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Asda Superstore, Dome Leisure Park, DONCASTER, Yorkshire, DN4 5NW

Pharmacy reference: 1090790

Type of pharmacy: Community

Date of inspection: 03/09/2019

Pharmacy context

This is a community pharmacy set within a supermarket. The supermarket forms part of a larger leisure complex on the outskirts of Doncaster, South Yorkshire. The pharmacy opens extended hours over seven days each week, including late into the evening. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It also offers some private health services, including the supply of travel health medicines. The pharmacy offers advice on the management of minor illnesses and long-term conditions.

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 identifies and manages the risks associated with its services. It keeps people's private information secure. And it responds appropriately to feedback it receives about its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they have the skills and knowledge required to protect the safety and wellbeing of vulnerable people. The pharmacy generally keeps all records it must by law. But some minor gaps in records for controlled drugs result in some incomplete audit trails.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The superintendent pharmacist's team reviewed these at least two yearly. SOPs had been updated following the introduction of the Falsified Medicines Directive (FMD). And pharmacy team members were currently working through training associated with some of these SOPs, they had signed off other SOPs to confirm they had read them. A locum pharmacist, on duty for the majority of the inspection, was informed of changes to SOPs through the system he used to book his shifts. And locum pharmacists confirmed their understanding of the SOPs during the booking process. SOPs included details of the roles and responsibilities of pharmacy team members. And the team was observed working in accordance with the sale of medicines and dispensary SOPs during the inspection. A trainee member of the team explained what tasks she could and couldn't complete if the RP took absence from the premises.

The pharmacy had some baskets of assembled medicines in a large box at floor level and it had some baskets of medicines, waiting for assembly, on the dispensary floor. But work benches were relatively clear. A discussion took place about the use of the available space and the practice of storing baskets of medicines at floor level was discouraged. The pharmacy manager explained the pharmacy had become busier in recent years which occasionally impacted on space management in the dispensary. NHS item numbers had increased by approximately 20% since the last inspection in 2015. The manager explained the pharmacy team had requested additional shelving to the side of the dispensary. But this had not been approved as an area of priority. Workflow was organised with priority given to dispensing prescriptions for people waiting or shopping instore.

The pharmacy had a near-miss error reporting process in place. Near-miss error rates were low compared to the volume of items dispensed. And pharmacy team members explained that they reported mistakes which reached the pharmacist. They did not record details of mistakes made during the dispensing process and corrected before they reached the pharmacist. A discussion took place about how reporting all types of mistakes could help inform shared learning processes within the pharmacy. The dispensing process was efficient with different people involved wherever possible at each stage of the process to maximise the number of checks applied prior to the final accuracy check. And pharmacy team members ticked through information on the medicine when cross-checking it against the prescription form and medicine label. A pharmacist reviewed near-miss records weekly. And improvement actions were recorded and shared with pharmacy team members. Pharmacy team members could discuss actions they took to reduce risk. For example, highlighting similar sounding

medicines on the dispensary shelves to prompt additional checks.

The pharmacy had an incident reporting procedure. The RP explained how he would manage a dispensing incident with the person affected. And follow the pharmacy's internal reporting processes to report the error to the superintendent pharmacist's office. Evidence of incident reporting was made available during the inspection. The pharmacy documented some details of learning following these types of mistakes. And following an incident the team highlighted people's medication records to prompt extra caution during the dispensing process. But the pharmacy did not always act by reviewing stock placement following incidents. For example, multiple boxes of different strengths of a medicine involved in an incident were mixed together on the dispensary shelves. This was brought to the direct attention of the RP who acted immediately to re-organise the stock.

The pharmacy advertised its concerns procedure prominently. And pharmacy team members on duty could explain how they would manage and escalate a concern about the pharmacy. The RP explained he had worked regularly at the pharmacy and felt the team were proactive at managing minor concerns and feedback. For example, he had provided details of the prescription pre-payment certificate service when a concern about the cost of treatment arose. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. And it published the results of this questionnaire for people using the pharmacy to see.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. And the notice was updated when the RP changed mid-inspection. Entries in the responsible pharmacist record complied with legal requirements. But there were some empty lines left between some entries on occasion. The sample of the controlled drug (CD) register examined was generally compliant with legal requirements. But the pharmacy did not always enter the address of the wholesaler when entering receipt of a CD. And some page headers were not completed in full. For example, the formulation of methadone was not completed at the top of each page of the register. The pharmacy maintained running balances in the register. And it checked these balances against physical stock weekly. A physical balance check of MST Continus 10mg tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. The pharmacy kept records for private prescriptions and emergency supplies within an electronic Prescription Only Medicine (POM) register. Entries within the register met legal requirements. The pharmacy retained completed certificates of conformity for unlicensed medicines with full audit trails completed to show who each medicine had been supplied to.

The pharmacy displayed a privacy notice and details of how it looked after people's information within its practice leaflet. Pharmacy team members completed mandatory information governance training and a trainee explained how confidentiality requirements had been covered thoroughly during her induction. The pharmacy stored personal identifiable information in staff only areas of the pharmacy. A small amount of personal identifiable records were seen in the consultation room. But the door to the room was locked and the team confirmed the information would be removed prior to the room being used for a private consultation. The pharmacy had submitted its annual NHS data security and protection toolkit as required. It disposed of confidential waste by using a heavy-duty shredder.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed e-learning on the subject and pharmacists had completed level two safeguarding training. The RP discussed how he had applied what he had learnt when engaging with people. Pharmacy team members could explain how they would recognise and report a safeguarding concern to the RP in the first instance. And the RP was aware of reporting requirements

and had access to contact information for local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. It has good systems in place in respect of its training arrangements for new staff. And pharmacy team members engage in ongoing learning relating to their roles. Pharmacy team members take part in regular conversations relating to risk management and safety. And they have the confidence to follow the pharmacy's feedback processes should they need to.

Inspector's evidence

On duty at the beginning of the inspection was the pharmacist manager and a trainee member of staff who had worked in the pharmacy for approximately five weeks. The locum pharmacist and a trainee dispenser relieved these two members of the team part-way through the inspection. The manager explained that two pharmacists normally overlapped shifts over the lunch period. But the second pharmacist manager was on annual leave on the day of inspection. And arrangements with the regular locums used to cover this period meant that double-up cover was not being provided for some of this leave. The pharmacy also employed three qualified dispensers, two trainee dispensers and the new member of staff who was completing induction training. The manager explained the pharmacy had a 20-hour part time vacancy. But it was not actively being recruited to as staffing levels and skill mix were being reviewed.

Pharmacy team members explained the pharmacy had struggled to maintain full staffing levels over the past few years. They explained once staff had qualified they often left and thought this could be due to the pharmacy's late night and weekend opening hours. Pharmacy team members on duty felt fully supported in their training roles. They confirmed they were able to ask questions and received timely support to assist their learning. The pharmacy identified risks associated with trainee members of the team. And it managed these well. For example, trainees completed medicine counter training prior to moving into the dispensary. A trainee dispenser, who had recently moved into the dispensary explained how she did not undertake some high-risk tasks. For example, dispensing CDs. Pharmacy team members were encouraged to complete ongoing learning associated with their roles. This largely took the form of e-learning. And a member of the team demonstrated their training records during the inspection. Staff on duty had not been through a formal appraisal to date. But the trainee dispenser explained she had received a one-to-one review with a manager prior to progressing on to work in the dispensary.

The pharmacy team was busy during the inspection. A trainee was observed using appropriate questioning techniques when managing a request for a Pharmacy (P) medicine. And she referred queries and information to pharmacists when making these types of sales. The pharmacy had some targets in place for the services it provided. Its team members explained progress towards meeting targets was discussed with them. And they supported pharmacists in identifying people who may benefit from services by applying relevant checks to people's medication records during the dispensing process. The RP discussed how he was supported in applying his professional judgement when undertaking services.

The pharmacy team communicated mainly through handover briefings during shift changes. Pharmacy

team members regularly got the chance to speak with a manager one-to-one. And felt that due to shift patterns this method of continual verbal communication worked well. A pharmacist manager completed regular patient safety reviews and internal audits. These were documented, and results were fed back to the team. The pharmacy had a whistleblowing policy in place. And pharmacy team members were aware of how they could raise a concern or provide feedback if required. Both team members spoken to confirmed they would feel confident to raise a concern and escalate it if necessary. The RP confirmed he was aware of feedback arrangements should he have any concerns.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was at the far-side of the supermarket. And it was clearly signposted from both the road and within the store. Pharmacy team members reported maintenance and IT issues to the supermarket management team. Designated work maintenance teams managed all concerns. There were no outstanding maintenance issues found during the inspection. The pharmacy had heating and air conditioning. Lighting throughout the premises was bright. Antibacterial soap and paper towels were available at a designated hand washing sink.

The dispensary was a sufficient size for the level of activity carried out over the extended opening hours. It was clean and work benches were free from clutter. But some floor space in the dispensary was being used to hold the baskets of assembled medicines. A discussion took place about risks associated with holding medicines in this way. The pharmacy had a consultation room. This was clearly sign-posted and available for use. The room was a good size and was easily accessible to people using wheelchairs or pushchairs. The room was clean, and it was relatively well organised.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It has up-to-date procedures and protocols to support the pharmacy team in delivering its services. The pharmacy obtains its medicines from reputable sources. And it has appropriate systems in place to ensure it keeps these medicines safe and secure. People visiting the pharmacy receive advice and information to help them take their medicine safely. But the pharmacy doesn't always provide written information to further help people who are taking high-risk medicines.

Inspector's evidence

The pharmacy was accessible to all and it was clearly signposted. Entry to the store was via automatic doors and ample free parking was provided in the store's car park. The pharmacy displayed its opening times. And it advertised the services it provided. Further information relating to its services was published in its practice leaflet and this was readily available for people to take. Pharmacy team members understood the requirement to signpost people on to another healthcare provider or pharmacy, should the pharmacy not be able to provide a service or a medicine. And they accompanied people to the healthcare aisle of the store when signposting to products available in store.

The pharmacy annotated prescription bags with stickers to help identify eligible people for services such as Medicines Use reviews (MURs). The RP reflected on the outcomes of the service when working at the pharmacy. For example, an MUR had picked up that a person was taking both the brand and generic variations of a medicine. The person had been advised of the need to only take one of the medicines, potential side-effects of taking both were discussed. And the outcome had included shared learning amongst the team about the need to counsel people when the brands of their medicine changed. Up-to-date patient group directions were in place to support the supply of prescription only medicines through both NHS and private services. And the pharmacy retained pharmacists training records for these services. The pharmacy's travel health service was popular with people accessing the pharmacy before their travels for advice and malaria prophylaxis medication.

The pharmacy team generally highlighted high-risk medicines on assembled bags of medicines by applying stickers. The RP explained this led to referral to the pharmacist for counselling and checks of monitoring records (when available) at the time an assembled medicine was handed out. The RP was familiar with the requirements of the valproate Pregnancy Prevention Programme (PPP). But high-risk warning cards were not readily available to issue to people in the high-risk group. A discussion took place about the importance of keeping these cards available to ensure all pharmacists supplying valproate worked in accordance with the PPP.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. And wherever possible labelling and assembling tasks were completed by two different members of the team. The pharmacy team kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy retained an audit trail for its prescription collection service. A pharmacy team member demonstrated the audit

trails and discussed how the pharmacy would liaise with surgeries to chase missing prescriptions or query changes.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). They explained FMD had been mentioned in passing and they had read some information about it. But they were not clear of how the pharmacy would comply locally with FMD requirements. The pharmacy team received safety alerts and drug recalls via email to the supermarket's main office. It acted upon these alerts in a timely manner and kept a copy for reference purposes.

The pharmacy stored Pharmacy medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in their original packaging. Some shelves required organisation as different formulations and strengths of the same medicine had occasionally fallen into each other. Pharmacy team members were observed applying thorough checks of picked medicines against prescription forms and medicine labels during the dispensing process which largely mitigated the risk of a dispensing error occurring. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Short-dated medicines were identifiable. The team annotated details of opening dates on bottles of liquid medicines. And a bottle of ranitidine oral solution annotated with these details was brought to the attention of the RP, as it had been open longer than its shortened expiry date. No other out-of-date medicines were found during random checks of dispensary stock. Medical waste bins, clinical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. The pharmacy pre-assembled methadone against current prescriptions. And stored these pre-assembled doses in an organised manner within the cabinet. The RP was observed checking details of the prescription against the assembled medicine and with the person attending prior to supervising consumption. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were highlighted to prompt additional checks during the dispensing process.

The pharmacy's fridge was clean and stock inside was stored in an organised manner. Assembled medicines were held in clear bags and a pharmacy team member was observed checking the contents of the bag with the pharmacist prior to handing out the assembled medicine. But the fridge was nearing its storage capacity and some boxes of medicines were physically touching the back wall of the fridge. A discussion took place with the RP about moving these medicines forward to avoid any risk of them being exposed to extremes in temperature. The pharmacy team monitored fridge temperatures and recorded these. A sample of these records confirmed the fridge was operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment and facilities it needs for providing its services. It monitors its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. The company intranet and the internet provided the team with further information. Computers were password protected and the layout of the premises protected all information on computer monitors from unauthorised view. Pharmacists and most members of the support team had working NHS smart cards. The pharmacy's weekly audit identified steps being taken to have personal smartcards in place for the whole team. The pharmacy team used a cordless telephone handset. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. These included separate measures for use with methadone. The pharmacy had clean counting equipment for tablets and capsules, and this included a separate triangle for use with cytotoxic medicines. The pharmacy monitored its equipment. For example, electrical equipment was subject to portable appliance testing. Dates on equipment indicated these checks had last taken place in February 2018. Some older equipment which had previously been used to support private health check services was secured in a cupboard. This prevented any risk of the equipment being used without the necessary checks being made to ensure it was in safe working order.

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.