General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Asda Superstore, Owlcotes Shopping Centre, PUDSEY, West Yorkshire, LS28 6AN

Pharmacy reference: 1090791

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This community pharmacy is in an Asda supermarket. The pharmacy dispenses NHS and private prescriptions. And it supplies medicines in multi-compartment compliance packs to help some people take their medicines. The pharmacy provides the seasonal flu vaccination service, malaria prophylaxis medicines and medication to delay periods. And it provides a supervised methadone consumption service. The pharmacy offers the community pharmacist consultation service (CPCS).

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	1.2	Good practice	The pharmacy team members respond competently when errors happen. All the team members are informed when errors happen, and they share learning. They record their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
2. Staff	Good practice	2.4	Good practice	The pharmacy promotes an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. The team openly discuss and regularly review errors they make. So, they can improve their performance and skills.
		2.5	Good practice	The pharmacy encourages the team members to share ideas on how to improve the efficient delivery of services. And they introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. The pharmacy team members respond competently when errors happen. They record their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy has arrangements to protect people’s private information. And people using the pharmacy can raise concerns and provide feedback. The pharmacy keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy kept the SOPs electronically. The team members accessed the SOPs and answered a few questions to confirm they had read and understood the SOPs. The pharmacy received alerts about new SOPs or changes via an internal notification system. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these near miss errors. And the team member involved recorded their own error. A sample of near miss error records looked at found that the team usually recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record their thoughts on what caused the error and the actions they had taken to prevent the error happening again. One of the pharmacist managers reviewed the near miss records each week to spot patterns and make changes to processes. The other pharmacist manager looked through the review and shared the outcome of the review with all the team. Recent reviews highlighted patterns with the team picking the wrong type of inhaler. The review reported that the team members were reminded to always double check the inhalers selected. The pharmacy recorded dispensing incidents electronically and shared them with the team. These were errors identified after the person had received their medicines. The team members discussed an incident when one person received another person’s medicines. And they identified the two people had the same first name but different surnames. The team discussed the importance of checking the person’s name and address by asking them for both details rather than telling the person to confirm the details. And to ask for the person’s date of birth. The team members were asked to not rush when handing over people’s completed prescriptions. The team recorded the error on the person’s electronic medication record (PMR) and in the team's communication book. So, all team members were aware of the error.

The pharmacy completed monthly patient safety reviews. A recent review highlighted errors with the wrong strength of medicine. The team members were reminded to always read the prescription properly. And to be careful with medicines that looked and sounded alike (LASA). For example, amitriptyline and amlodipine. The team placed stickers with ‘risky’ printed on them to the shelves holding LASA medicines. And colour coded the plastic dividers. The stickers and coloured dividers prompted the team to check the medicine picked when dispensing.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it

had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy displayed the results from the latest survey in the consultation room and published them on the NHS.uk website. The latest survey included positive comments about the efficient service provided by the team. The survey highlighted comments for improvement from people about the comfort and convenience of the waiting area. The survey results indicated that the team was to review the waiting area to see what changes it could make. The pharmacy was next to the opticians and several seats were available in the area between the two departments for people to use.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details about the confidential data it kept and how it complied with legal requirements. The team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding procedure and team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had not had the occasion to raise a safeguarding concern.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And team members support each other in their day-to-day work. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives some team members regular feedback on their performance. The pharmacy encourages the team members to share ideas on how to improve the efficient delivery of services. And supports team members to make changes to improve the safe delivery of these services.

Inspector's evidence

Two part-time pharmacist managers covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of six part-time qualified dispensers. At the time of the inspection one of the pharmacist managers and two of the dispensers were on duty. The pharmacy provided extra training through e-learning modules. The pharmacy team members had their own log in and could see what training they needed to do. The team members could also see how they were progressing with their training. And they had protected time to complete the training. The team usually used quieter times such as early morning or evening shifts to do the training. The resident pharmacists monitored completion of the training.

The pharmacy didn't have formal meetings as team members worked different shifts. The resident pharmacists shared key pieces of information with team members when they were on duty. The pharmacy had a communications book to record information for all the team to be aware of. And the team members read the book at the start of their shift to make sure they were up to date. The pharmacy also used a WhatsApp group to ensure all team members were kept up-to-date with information. Such as changes made following the monthly patient safety report and to inform them of the release of new training modules. The information shared on the WhatsApp did not include any confidential information. The WhatsApp facility allowed the pharmacist manager to see who had read the information. The team printed off and read the newsletter sent from the pharmacy team Asda head office.

The resident pharmacists received appraisals as part of the company process. And other team members received informal feedback rather then formal performance reviews. The resident pharmacists gave informal feedback to the team via the WhatsApp group. And awarded team members with stars in response to positive comments from people using the pharmacy. The pharmacy team also provided feedback to the pharmacy team at Asda head office about locum pharmacists. Team members could suggest changes to processes or new ideas of working. One of the dispensers suggested spreading out the completed prescriptions awaiting supply by adding a basket on to the shelf alongside the large box holding the prescriptions. So, the team could easily locate the prescription and reduce the risk of selecting the wrong prescription. The team had implemented this. Another dispenser suggested storing pain relief medicines on dedicated shelves to help the team pick the correct products. This had also been implemented. The pharmacy had targets for services and the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The dispensary was small with limited working space. The team managed this by keeping the dispensary work benches free of clutter. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. And the pharmacists invited people in to the consultation room to take their methadone doses. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. And they manage the pharmacy services well. The team identifies people prescribed high-risk medicines. And it provides people with appropriate advice about their medicines. The pharmacy team members keep records of prescription requests. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines well.

Inspector's evidence

People accessed the pharmacy via the store entrance. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges. The pharmacist spent time with a person who wanted to buy a medicine who had difficulty with hearing. The pharmacist took the person to one side, away from other people at the pharmacy counter and asked them to write down their request and any medication they were taking before selling the medicine. To ensure the medicine was appropriate. The pharmacist gave the person clear instructions on how to use the medicine. The pharmacy had up-to-date patient group directions (PGDs). These gave the pharmacists the legal authority to provide the services such as the flu vaccinations and the supply of malaria prophylaxis medicines. The flu vaccination service was popular. People liked the convenience of the service. The pharmacy trained all pharmacists to provide the flu vaccination service so the pharmacy could offer an appointment or walk-in service to people. The pharmacy had a light linked to the computer and to PharmOutcomes. The light had different colours to indicate the different messages sent via PharmOutcomes. Such as a CPCS referral, and emails from Asda head office. So, the team were alert to the message and could promptly respond.

The pharmacy provided multi-compartment compliance packs to help 11 people take their medicines. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team picked the stock before dispensing so they knew what medicines had to be ordered. The team members usually dispensed the packs later in the day and at weekends when they were less busy with other jobs. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The team used baskets labelled with the person’s name and address to store the medication list, the medicine stock and completed packs. The pharmacy received copies from people of their hospital discharge summaries from the person who had the packs or from their GP. The team checked the discharge summary for changes or new items. And requested prescriptions when required.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses with the prescription in the controlled drugs cabinet in baskets labelled with the person’s name. To reduce the risk of selecting the wrong one.

The team members provided a repeat prescription ordering service. The team asked people to contact the pharmacy to order their medicines or drop off the repeat prescription slip a week before the next

supply. This gave time for the team to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of the requests and regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had completed regular audits of the supply of valproate to check if anyone met the criteria. The audits found that none of the people prescribed valproate met the PPP criteria. The pharmacy had the PPP pack to provide people with information when required. The team completed checks with other people taking high-risk medicines. And recorded details of these conversations such as asking people prescribed diabetic medicines if they had an eye check or foot check in the last 12 months.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacist wrote on the CD sticker the CD medicine such as pregabalin. So, all team members knew that the prescription had to be supplied within the 28-day legal limit. The pharmacist also wrote CD on the prescription and used a highlighter pen to emphasise this. The team placed CD stickers on the shelves holding CD medicines to remind them of the legal category of these medicines. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The team contacted people to tell them when their medicines were ready to collect. The team usually did this of an evening as most people would be at home.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 20 January 2020. The team highlighted the expiry date on medicines with a short expiry date. And wrote the expiry date on to the packaging. No out-of-date stock was found. The pharmacy had stickers on the shelves that informed the team of the maximum number of packs to keep. So, the team could ensure the shelves were tidy. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 25 October 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team separated the sugar-free and original versions of methadone in the CD cabinet. The team used appropriate denaturing kits to destroy CDs. And promptly destroyed CDs returned by people.

The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). But due to a technical fault the team were not scanning FMD compliant medicines. The pharmacist manager had reported the problem. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the team mostly uses the pharmacy’s facilities and equipment in a way to protect people’s private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate measures for methadone and separate cylinders for measuring water when preparing liquid antibiotics. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door that allowed the viewing of stock without the door being open for a long time. The team labelled the shelves in the fridge to indicate the stock held.

The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. And it kept the computer screen in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary which had restricted access. A tote box containing completed prescriptions was in the consultation room. The lid was loosely placed on the box. The team was storing the medicines in the room as the shelves for storing completed prescriptions were full. Some completed forms for services such as CPCS and the flu vaccination service that included people’s confidential information were also in the consultation room. The door into the consultation room from the retail area was locked. The team used cordless telephones to make sure telephone conversations were held in private.

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.