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: 04/01/2024

Pharmacy context

This pharmacy is in an Asda supermarket near to Pudsey, a large town in West Yorkshire. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides a few people with their medicines in multi-compartment compliance packs to help them take their medication properly. The pharmacy provides other NHS services including the hypertension case finding service and the pharmacy contraception service. And the NHS community pharmacist consultation service.

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 well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it generally keeps the records it needs to by law. Team members suitably protect people's confidential information, and they understand their role to help protect vulnerable people. The team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. Team members accessed the SOPs through personal log in details. And completed a quiz connected to each SOP to show they had read, understood and would follow the SOP. The regular pharmacists received alerts about new SOPs or changes via an internal notification system. And they monitored team members progress in completing the reading of the SOPs.

The pharmacist asked team members to correct mistakes found at the final check of a prescription. Records of these errors, known as near misses, were kept and the team member involved was responsible for completing them. A sample of near miss records found team members usually recorded details of what had been prescribed and dispensed to spot patterns. But they did not always record their thoughts on what caused the error and the actions they had taken to prevent the error happening again. The pharmacist completed a weekly review of near miss errors and used a recent review to remind team members to complete the record. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the error, and they discussed how to prevent such errors from happening.

The pharmacists undertook monthly reviews of the near miss records and dispensing incident reports to spot patterns and take appropriate action to prevent errors from reoccurring. Team members were asked to read the outcome of the review which was also discussed at team meetings. A recent meeting reminded team members to focus on the task they were completing and not to distract each other. Shelves holding medicines that were at higher risk of being picked in error because the packaging looked similar, or the medicines were similar in name were clearly marked. This prompted team members to check the medicine they had selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. A poster displayed by the pharmacy counter provided people with information on how to raise a concern. The company website provided information on how to provide feedback. And comments left on social media platforms were monitored to ensure appropriate responses were provided.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers mostly met legal requirements. The header section on some CD registers had not been completed. Appropriate records were kept of CDs returned by people for destruction. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. And a random balance check undertaken during the inspection was correct. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty.

Team members knew how to manage people's confidential information and the pharmacy displayed information on the General Data Protection Regulations (GDPR). They separated confidential waste for shredding offsite. The pharmacy provided the team with safeguarding training and guidance. And the pharmacist had completed training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had not had the occasion to respond to a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They generally have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge. However, some team members who wish to support the team with additional tasks require appropriate training to enable them to undertake these roles safely.

Inspector's evidence

Two full-time pharmacists with managerial responsibilities covered most of the opening hours. Locum pharmacists provided cover for the remaining hours. The pharmacy team consisted of five part-time dispensers, one medicines counter assistant (MCA) and a trainee MCA. At the time of the inspection one of the regular pharmacists, one of the dispensers and the trainee MCA were on duty. The trainee MCA was observed undertaking dispensing activities such as labelling but their training programme did not include dispensing activities. This was highlighted to the pharmacist who was aware the training programme did not include dispensing. And advised that the trainee MCA only undertook dispensing tasks occasionally to support the team. After discussing this with the inspector the pharmacist asked the trainee MCA to stop dispensing. The team had been supported by colleagues who usually worked in other areas of the store and had received MCA training. But these team members rarely worked in the pharmacy, so they had limited opportunities to maintain their knowledge and skills. This had sometimes led to errors such as the wrong medication being handed over to a person. The pharmacist was informed by the store management that this support was on hold so planned to provide refresher training to these team members if they returned to the pharmacy.

Team members worked well together and knew how to undertake key tasks such as date checking which was allocated to different team members each month. This ensured these tasks were completed regularly, including times when team numbers were reduced such as planned and unplanned absence. The pharmacy held team meetings where key pieces of information such as new services were shared with team members. The team used a communication platform and a communications book to record information for all team members to be aware of. The team read the newsletter regularly sent from the Superintendent Pharmacist’s team which provided information such as changes to legislation.

The pharmacy provided extra training to team members through e-learning modules and they had protected time at work to complete the training. Notification of new training modules and completion dates were sent to the regular pharmacists who monitored team members progression in completing the training. Team members received formal performance reviews so they could identify opportunities to develop their knowledge and skills. The pharmacy had targets for its services which the pharmacists reported were achievable. And the services were offered when they would benefit people and improve their health.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and generally provide a suitable environment for the services provided. It has appropriate facilities to meet the needs of people requiring privacy when using its services. But the room used for private conversations is cluttered.

Inspector's evidence

The pharmacy, in particular the dispensary, was small with limited working space. Team members generally managed the limited space well but occasionally some baskets were piled on top of each other, creating an increased risk of errors. Team members worked in a tidy and organised manner, and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy was clean and hygienic, it had separate sinks for the preparation of medicines and alcohol gel was available for hand cleansing. The pharmacy had a defined professional area and items for sale in this area were healthcare related.

The pharmacy had a soundproof consultation room that team members used for private conversations with people and when providing services. However, some boxes holding medicine stock such as nutritional drinks were stored in the room. This reduced the space available for people to move around and gave the room a cluttered appearance. The premises were secure and there was restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people and opportunities are taken to raise awareness of the services. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via the store entrance through an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the correct product was supplied. And they knew when to refer requests to the pharmacist.

The hypertension case finding service was popular and had resulted in some people being referred for further tests. Stickers were attached to the bags holding dispensed medicines to prompt team members to speak to people about the service. Most referrals to the NHS community pharmacist consultation service came from NHS 111 which reflected the pharmacy's opening hours. To increase awareness of the NHS pharmacy contraception service the team placed information about the service in the bags holding dispensed oral contraceptive medication. And took the opportunity when handing over the medication to discuss the service with the person.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. Prescriptions were requested several days before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication, dosage and dose times which was referred to throughout the dispensing and checking of the packs. The team recorded the descriptions of the medicines within the packs but did not always supply the manufacturer's packaging leaflets. So, people could identify the medicines in the packs but had limited information about the medicines they were taking. The pharmacy supplied some medicines as supervised doses which were prepared in advance to reduce the workload pressure of dispensing at the time of supply. The prepared doses were stored securely and people's doses separated to reduce the risk of selecting the wrong one.

The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the new rules requiring valproate to be supplied in the manufacturer's original outer packaging. Details of the new rules were clearly displayed for team members to refer to. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and reported no-one prescribed valproate met the criteria.

Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy had a system to ensure prescriptions with CDs were supplied within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy sent people a text message to advise them when their prescription was ready to collect.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock and marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines remained safe to use. And these medicines were included in the date checking process so medicines that had reached the shelf life could be identified and removed. The team checked and recorded fridge temperatures each day and a sample of these records were within the correct range. CDs were stored securely and out-of-date CDs were separated and clearly marked. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the company communication platform. The team responded appropriately to these alerts and kept a record of their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And a fridge for holding medicines requiring storage at this temperature. The pharmacy completed safety checks on the electrical equipment. And equipment such as the blood pressure monitor was replaced annually to ensure accurate readings were taken.

The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.