General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Asda Pharmacy, Asda Superstore, Old Mill Lane, BARNSLEY, South Yorkshire, S71 1LN

**Pharmacy reference:** 1090793

**Type of pharmacy:** Community

**Date of inspection:** 30/05/2019

## Pharmacy context

This community pharmacy is in an Asda Superstore in Barnsley, South Yorkshire. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It provides a substance misuse service including needle exchange and supervised consumption. It provides private services such as hair loss treatment and period delay treatment. And it provides a seasonal flu vaccination service.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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** | Standards met | 1.4 | Good practice | The pharmacy advertises how people can provide feedback and raise concerns, and the team it is proactive in using the feedback it receives, to improve its services. |
| **2. Staff** | Standards met | 2.1 | Good practice | The pharmacy regularly assesses its staffing profile to make sure staffing levels and skill mix remain appropriate following feedback. And following the introduction of new services or changes to the business. |
| | | 2.2 | Good practice | The pharmacy is good at supporting its team members to complete training. And this helps them improve their knowledge and skills. And they can tailor their training to meet their own personal needs. |
| **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 has robust processes and procedures, so the team can manage the risks to its services. And it mostly keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns, and it is good at using the feedback it receives, to improve its services. The pharmacy keeps people's private information safe. It has processes available to its team members, to help protect the welfare of vulnerable people. And the pharmacy team members all complete relevant training to their role so they know what to do if they have a safeguarding concern. The pharmacy's team members record errors that happen when dispensing. They discuss their learning. And they use this information to make changes to help prevent similar mistakes happening again.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. These procedures were set to be reviewed every two years. This ensured that they were still relevant and up to date. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs documented who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with. And there was evidence that indicated they had read and understood the contents of the SOPs that were relevant to their role.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist or the accuracy checking technician (ACT) typically spotted the error and then made the team member aware of it. And then asked them to rectify it. A log was used to record details of the errors. The log had different sections to be completed. For example, the time of the error and the identity of the team members who were involved. But these sections were not always completed. The regular pharmacists analysed the near misses each month. And the findings were documented and discussed with the team. The team members said that they had made some errors in selecting the incorrect strength of medicines that looked similar or had similar sounding names. The team members separated these medicines on the dispensary shelves to reduce the risk of the errors happening again. The pharmacist said that the separation of had reduced the number of these errors.

The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. It recorded the details of the errors on to an electronic reporting form and the form was sent to the superintendent pharmacist's team. This was done within 48 hours of the error being identified. The form was printed and filed for future reference. The pharmacy had recently supplied a person with the incorrect strength of an inhaler. The team members were asked to re-read the SOP on dispensing. There was evidence available that showed the task had been completed. The team had also put an alert sticker next to where they stored the inhaler to remind them of the error each time they selected the medicine.

The pharmacy had a notice in the retail area which detailed how people could make a complaint. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The results of the 2019 survey was displayed in the retail area and were generally positive. The team said the time they took to dispense prescriptions was seen by many people as an area of practice that needed improving. To improve, the team analysed the staff rotas and made

changes to ensure more team members were present during busier periods of the working day.

The pharmacy had up to date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacist register was correctly completed. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained and audited every week. A random CD item was balance checked and verified with the running balance in the register (Concerta 18mg X 95). A CD destruction register was maintained to record patient returned medicines. And it was complete and up to date. The pharmacy kept private prescription and emergency supply records and they were correctly completed. They recorded any unlicensed medicines supplied, but two examples did not include the details of the authorising prescriber. This is not in line with MHRA requirements.

The pharmacy had an information governance (IG) policy for the team members to follow, so they could protect people's private information and data. The team members understood the importance of protecting the confidentiality of the people using pharmacy services. The team were trained on how to handle private information and had a working knowledge of data protection requirements and General Data Protection Regulation (GDPR). A data handling policy was on display in the retail area. The pharmacy stored confidential waste in a separate area of the dispensary. The waste was then destroyed. All team members and superstore colleagues who regularly access the dispensary had signed confidentiality agreements.

The two regular pharmacists and all regular locum pharmacists had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had completed an Asda module on safeguarding. The team members gave several examples of symptoms that would raise their concerns. The team had access to the local safeguarding board’s contact details and an SOP on how they should handle a potential concern. The team said that if they had a concern they would refer to the pharmacist on duty. And ask them to assess the concern.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy regularly reviews the times when team members work to make sure they are there to support the pharmacy when it is busy. The pharmacy is good at supporting its team members to complete training. And this helps them improve their knowledge and skills. And they can tailor their training to meet their own personal needs to make sure their knowledge is up to date. The pharmacy provides its team members with a process to raise professional concerns if necessary. And they feel comfortable in providing feedback.

### Inspector's evidence

At the time of the inspection, the team members present were two full-time resident pharmacists and four part-time pharmacy assistants. Other team members who were not present included six part-time pharmacy assistants. The team members often worked overtime to cover both planned and unplanned absences. The pharmacists shifts overlapped for two hours each day. This allowed the pharmacy to offer consultations and services to people, while continuing to provide a full dispensing service. The team members tried not to take time off in December. So they could help support the pharmacy during its busiest period. The pharmacy had recently reviewed the staffing profile. And it did this regularly to make sure staffing levels and skill mix remained appropriate following the introduction of new services or changes to business. It had made changes to ensure that more team members were present around 7pm. The team said that this was because a local out of hours service was very busy at this time. And many people who used the service, brought their prescriptions to the pharmacy to be dispensed.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy had a structured process to assist its team members to engage in ongoing learning. The team had access to an online learning programme called Helo. The programme consisted of several modules that the team were given protected time to complete. The modules were often mandatory and were based on various topics or new SOPs. Other modules could be completed voluntarily and were often done when team members wanted to learn about a certain healthcare topic. The team said that as the pharmacy was open early and closed late, they had plenty of time to train without distractions when the pharmacy was quiet.

The team members attended a team meeting which was held every one to two months. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. The team discussed patient safety and talked about any errors openly and honestly. They could suggest ways to make improvements to the service provided. The team said that they recently asked for additional training on a new online error reporting system. The team said that training allowed them to report any errors made without one of the regular pharmacists being present.

The pharmacy did not provide its team members with a structured appraisal process. But the team

members were regularly told how they were performing via open conversations with the two pharmacists. The team said that the process worked well, and they were able to openly discuss various topics. Such as their progress and any training needs. A team member said she had recently asked for training on how to spot the signs of a fraudulent prescription.

The team members confirmed that they were able to discuss any professional concerns with the pharmacists, the store manager or a team member based at the company head office. And they were aware of how they could raise concerns externally if they required.

The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team said that they did not feel any pressure to achieve the targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

### Inspector's evidence

The pharmacy was generally clean, hygienic and well maintained. Floor spaces were mostly clear, with no obvious trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC and a sink with hot and cold running water and other facilities for hand washing.  The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance.  The lighting was bright, and the temperature was comfortable throughout inspection. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy is accessible to people. And it provides its services safely and effectively. It manages and stores its medicines correctly. The team members identify people taking high-risk medicines, so they can monitor their treatment and give them advice. But they don't always have written information to give to people. And so, they may not be receiving the full information they need to take their medicines safely.

### Inspector's evidence

The pharmacy had level access from the superstore car park which led to an automatic entrance door. The pharmacy advertised the services it offered via displays in the retail area. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people's prescriptions from getting mixed up.

The team identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team were able to obtain additional material about the programme that they could provide to people to take away with them. The team had completed an audit to identify people they regularly supplied valproate to. Two people were identified as meeting the criteria of the programme. And they had been given advice by the pharmacist. The pharmacy used clear bags to store dispensed fridge and CD items. This allowed the team to do another visual check before the handed the medicine to the person. And they asked the person collecting to also check the item to ensure they were receiving the medicine they were expecting.

The team supplied methadone to a few people. The pharmacists said that they dispensed methadone during quieter periods of the day to avoid being distracted. The pharmacy stored dispensed instalments in a segregated part of the CD cabinet.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The

pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of stock every three months and the team kept a record of the activity. The records were complete. No out of date medicines were found following a random check of the dispensary stock. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The date of opening was recorded on liquid medication that had a short-shelf life once opened. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). But the pharmacy did have new software, installed scanners and a SOP available to assist the team to comply with the directive. The team had received any training on how to follow the directive.

The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people’s confidentiality.

### Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children.
The pharmacy used a range of CE quality marked measuring cylinders. And ones that were only used for dispensing methadone.

The medical fridge was of an appropriate size. The medicines inside were well organised.
The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The computers were password protected.

## 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. |