General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Hessle Road, HULL, North Humberside, HU3 4PE

Pharmacy reference: 1091652

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

This pharmacy is in an Asda supermarket. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some 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 emergency hormonal contraception. And the supervised methadone consumption service. The pharmacy provides the Community Pharmacist Consultation Service (CPCS).

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	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 team identifies and manages the risks associated with its services. The pharmacy team members respond well when errors happen. They record their errors and 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. Each team member had their own password to access the SOPs and other training modules. The pharmacist manager received alerts about new SOPs or changes via an internal notification system. The team members had a clear understanding of their role and referred queries from people to the pharmacist when necessary. 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 mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The near miss record had a section to capture a weekly review of the records to spot patterns and make changes to processes. But this was not completed. The pharmacy recorded dispensing incidents electronically and shared them with the team. These were errors identified after the person had received their medicines. Following an incident when one person's medicine had been incorrectly placed into another person's bag of medicines the team members were asked to refer to the prescription when placing medicines in to the bags. So, they could check that all the medicines on the prescription were in the bag. The pharmacy completed monthly and annual patient safety reports. The latest reports stated that the pharmacy had changed the team rota so more team members were on duty at busy times. During the inspection the number of dispensers on duty increased as the pharmacy became busier. The report stated the team were asked to take extra care when dispensing medicines with different strengths and to always double check the quantities dispensed. The team attached a list of medicines that looked alike and sounded alike (LASA) to the computer. Examples of LASA medicines included pantoprazole and paroxetine. The team referred to the list when labelling prescriptions to ensure they had selected the correct medicines.

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

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy 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 recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed internal safeguarding training and Dementia Friends training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives some team members regular feedback on their performance. The team members support each other in their day-to-day work. And they discuss their errors and how they can prevent them from happening again. So, they can improve their performance and skills.

Inspector's evidence

One full-time pharmacist manager covered some of the opening hours. Regular locum pharmacists provided cover for the remaining hours. The pharmacy team consisted of seven part-time qualified dispensers and two part-time trainee dispensers. The pharmacy displayed the team's training certificates in the consultation room for people to see. At the time of the inspection a locum pharmacist, three dispensers and one of the trainee dispensers were on duty. The pharmacy didn't have formal meetings as team members worked different shifts. The pharmacist manager shared key pieces of information with team members when they were on duty. And the pharmacy had a communications book to record information for all the team to be aware of.

The pharmacist manager received appraisals as part of the company appraisal process. But formal performance reviews for all the team members did not take place. So, they didn't have a chance to receive feedback and discuss development needs. The pharmacy provided extra training through e-learning modules. The team members had their own log in and could see what training they needed to do. And how they were progressing with their training. The team had some protected time to complete the training. 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 adequate for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy had seen an increase in prescription numbers and the section used for storing completed prescriptions was full. So, the team also used tote boxes stored in the middle of the dispensary to hold completed prescriptions. The team members were aware of the risks posed by this and had attached foam rolls to the edges of the boxes. So, they would not hurt themselves if they knocked against one of the boxes. The team had been informed that the pharmacy was relocating within the year as part of the refurbishment of the supermarket. The team had seen the plans for the new pharmacy which indicated the pharmacy would have more space. The pharmacy was clean 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. 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 provides services that support people's health needs. The team members generally manage the pharmacy services well. They identify potential issues that may affect the safe delivery of services. And they act to address them. The team members keep records of prescription requests. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via the store entrance through an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. 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 pharmacy displayed the posters from HM Government and the NHS about the Coronavirus. The team regularly accessed the Government website for updates on Coronavirus. The pharmacy had up-to-date patient group directions (PGDs). These gave the pharmacists the legal authority to provide services such as the supply of malaria prophylaxis medicines. The pharmacy had a USB device attached to the computer. The USB lit up in different colours to indicate the different messages sent via PharmOutcomes and Asda Head Office. Such as a referral to the community pharmacist consultation service (CPCS. So, the team were alert to the message and could promptly respond.

The pharmacy provided multi-compartment compliance packs to help around 26 people take their medicines. The team spent time with people new to the service explaining how to use the packs. And confirming when they took their medicines. So, the team could ensure the medicines were placed in the correct time slot. People received monthly or weekly supplies depending on their needs. One of the qualified dispensers managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team kept a list of people who received the packs. And used the list to record when the preparation of the packs was complete. 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. Some prescriptions were only sent from the GP team once a week. So, the team prepared and checked these packs once a week after the prescription arrived. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team dispensed the medicines in to the packs when the pharmacy was less busy with other tasks. And used the consultation room to dispense the medicines in to the packs. This was away from the distractions of the pharmacy counter and dispensary. The team recorded the descriptions of the products within the packs. But the team only supplied the manufacturer’s patient information leaflets every two to three months. The team stored completed packs on shelves labelled with the person’s name.

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 in the controlled drugs cabinet with the prescription attached to the dose due. The team members provided a repeat prescription ordering service. They used the pharmacy computer to place the prescriptions requests. And as an audit trail to

track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. And the team recorded this information on the person's electronic medication record (PMR). So, all team members were aware of this information if the person presented at the pharmacy. The pharmacy team stated that they were not aware of any people prescribed valproate that met the criteria of the Pregnancy Prevention Programme (PPP).

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 pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacist wrote CD on the prescription. And used a highlighter pen over the word CD and over the date on the prescription. 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 pharmacy team checked the expiry dates on stock. The team members shared the task amongst themselves to ensure it was completed. The pharmacy kept a date checking record. The last date check was on 01 March 2020. The team used a coloured sticker with the expiry date written on to highlight medicines with a short expiry date. No out-of-date stock was found. 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 Oramorph oral solution with three months use once opened had a date of opening of 09 March 2020 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 used appropriate denaturing kits to destroy CDs.

The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). But the team were not scanning FMD compliant products. 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 the internal communications system in to the main office in the store. The alert was sent to the pharmacy team to action and 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, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

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. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary which had restricted access. A few empty bottles used to provide people with their methadone doses were found in a medicine waste bin in the consultation room. The bottles still had the dispensing labels attached. Documents including some prescriptions containing people's confidential information were found in the consultation room. The door into the consultation room from the retail area was locked.

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.