

# Registered pharmacy inspection report

**Pharmacy Name:** Asda Pharmacy, Asda Superstore, Barton Dock Road, Urmston, MANCHESTER, Lancashire, M41 7BQ

**Pharmacy reference:** 1091675

**Type of pharmacy:** Community

**Date of inspection:** 07/03/2023

## Pharmacy context

This supermarket pharmacy is situated in a large retail development. It mainly prepares NHS prescription medicines, and it manages people's repeat prescriptions. The pharmacy provides other NHS services such as influenza vaccination, blood pressure checks and the Community Pharmacy Consultation Service (CPCS). The pharmacy also supplies weight-loss treatments against private prescriptions issued by Health Bridge Ltd trading as Zava, a CQC registered online doctor service provider. People access this service via the website [www.onlinedoctor.asda.com](http://www.onlinedoctor.asda.com).

## Overall inspection outcome

### Standards not all met

**Required Action:** Improvement Action Plan

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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards not all met	3.1	Standard not met	The pharmacy's website design allows people to select prescription only medicines before they complete an online questionnaire or have a consultation with a prescriber. This gives people the impression that they are likely to receive the medicine they select, and it could mean they may not always receive the most appropriate treatment.
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Overall, the pharmacy manages the risks associated with its services. It has written policies and procedures to help make sure it operates safely and the pharmacy team members generally follow these in practice. The team usually reviews its mistakes so that it can learn from them. Team members know how to protect and support vulnerable people, and they understand their role in securing people's confidential information.

### Inspector's evidence

The pharmacy had written procedures which covered safe dispensing of medicines, the responsible pharmacist (RP) regulations and controlled drugs (CDs). Staff members had read these procedures, and they passed a test to demonstrate they understood each procedure.

The dispenser and checker initialled dispensing labels for prescription medicines prepared in the pharmacy, which helped to clarify who was responsible for each prescription medication supplied. This assisted with investigating and managing mistakes.

Pharmacy team members discussed mistakes they identified when dispensing medicines. They addressed each of these incidents as they arose and reviewed them as a team at the end of each month. This meant the pharmacy encouraged additional learning opportunities to identify trends and mitigate risks in the dispensing process.

The pharmacy had a written complaint handling procedure, so staff members could effectively respond to any concerns. A publicly displayed notice included information on how people could make a complaint. The pharmacy had not completed a patient survey recently.

Zava directly handled any concerns that people raised about the weight-loss treatment service. The prescribing service shared and discussed any concerns with the pharmacy's superintendent office team when they were related to the pharmacy's involvement in the service.

People occasionally contacted the pharmacy about delivery issues with their weight-loss medicines, which were resolved by contacting the courier via Zava. And Zava contacted the pharmacy about people who reported they had not received their injectable weight-loss product or that it was faulty. The pharmacy investigated these incidents, but Zava did not always provide enough information. This meant the pharmacy had to contact Zava for further details in order to effectively investigate these issues.

The superintendent pharmacist had sought assurance from Zava about the weight-loss prescribing service to make sure the service operated safely. The pharmacy had completed risk assessments which identified inclusion and exclusion criteria and covered how information was shared with people's GP and how the prescribing service verified the weight of the person. Zava and the pharmacy's superintendent's office team attended a monthly clinical governance meeting to review incidents and patient feedback, which helped to manage patient safety for the online service.

Zava had completed a clinical audit of the weight-loss service and the superintendent had sight of this. The pharmacy kept a risk register specifically of injectable weight-loss service issues. This helped the

pharmacy to identify and manage risks in providing the service.

The pharmacy had professional indemnity cover for the services it provided. The RP displayed their RP notice, so the public could identify them. The pharmacy maintained the records required by law for the RP record and CD transactions. The team regularly checked the CD running balances and made corresponding records, which helped it to identify any discrepancies. The team kept records of unwanted CDs returned to the pharmacy for destruction. And the pharmacy kept records of flu vaccinations and other services that it provided.

Private prescription records generally contained the correct information. The prescriber's name and address were not always entered on the electronic private prescription record for supplied weight-loss products. But the manager, who was one of the regular pharmacists, said they would rectify this.

Staff members had completed training on protecting people's confidentiality and information governance. They securely stored and destroyed confidential material. Each team member used their own security card to access NHS electronic patient data and they used passwords to access this information. The pharmacy team entered people's verbal consent to receive the flu vaccination service on the electronic record. Team members said that they obtained verbal or written permission from people for the pharmacy to manage and obtain their repeat prescription. But they were unable to locate the records that supported this. A publicly displayed privacy notice explained how the pharmacy handled and managed people's personal information as required by the General Data Protection Regulation.

The two regular pharmacists had level three safeguarding accreditations. Team members had completed the pharmacy's safeguarding training. The pharmacy routinely reviewed each patient's patient medication record when supplying weight-loss products. This helped to identify people who might be receiving excessive quantities of these products.

The pharmacy manager recalled an individual who had registered more than one account for obtaining weight-loss product by using different email addresses. This was flagged to Zava who confirmed that it knew about these multiple accounts, and that the prescriber usually identified them. The superintendent subsequently advised that they would investigate this and make sure potentially duplicated accounts were monitored.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough staff to provide safe and effective services. Team members understand their individual roles and they work well together. Staff complete the right training for their roles.

### Inspector's evidence

The pharmacy team was subdivided into two areas: the main pharmacy area with the front counter and dispensary, and the hub where the weight-loss products were assembled and dispatched. The staff members present working in the main pharmacy included the RP, who was a temporary locum pharmacist, and a dispenser. The staff members present working in the hub included a dispenser and two trainee dispensers. Other team members who were not on duty included the manager, the regular pharmacist, and five trainee dispensers. All team members, including the RP, moved between the main pharmacy and hub according to workload. This meant the team had the flexibility to make sure it managed the fluctuations in service demand throughout the course of the working day.

The pharmacy had enough staff to comfortably manage the workload. There were two pharmacists simultaneously on duty for around four hours per day when the pharmacy was open on weekdays. The team usually had repeat prescription medicines and weight-loss products, ready in good time for when people needed them. The pharmacy's footfall was minimal. So, the team avoided sustained periods of increased workload pressure and it promptly served people.

Most of the trainee dispensers were progressing towards completing the appropriate training qualification for their role in a timely manner. They each had protected study time to keep advancing their training. The manager explained that two trainees, who started working at the pharmacy around three months ago, were due to be enrolled on training courses shortly. One team member's training had become protracted and they had only completed around three quarters of their training in seventeen months. The manager and trainee had a plan to finish the training in the next month.

The pharmacy manager, superintendent's office and Zava customer service teams had a joint weekly meeting. The teams worked together to resolve any ongoing issues. The manager explained that Zava promptly replied to queries about weight-loss prescriptions, which helped to make sure service users received a prompt and safe service. The pharmacy did not have any formal targets for the volume of services provided.

## Principle 3 - Premises Standards not all met

### Summary findings

The pharmacy's website design allows people to select prescription only medicines before they start a consultation. This gives people the impression that they are likely to receive the medicine they select and it could mean they may not always receive the most appropriate treatment. The website contains information about the pharmacy and the associated prescribing service. The premises are clean, secure, and spacious enough for the pharmacy's services, and it provides a professional environment for healthcare services.

### Inspector's evidence

The pharmacy had some COVID-19 infection control measures. A large screen on the front counter protected people visiting the pharmacy and the pharmacy staff.

The premises' level of cleanliness was appropriate for the services provided. It had the space needed to allow the pharmacy to dispense medicines safely. The dispensary was behind a tall partition, so any confidential information could not be easily viewed from the public areas. The separate hub was a secure facility with access restricted to pharmacy team members. Staff could secure the pharmacy premises.

The consultation room offered the privacy necessary to enable confidential discussion. It was accessible from the retail area, could accommodate two people and was suitably equipped. But its availability was not prominently advertised, so people may not always be aware of this facility.

The pharmacy's website included its address and contact telephone number, the owner's address, the superintendent pharmacist's identity, and a link to check their registration status. It also has information about Zava and its prescribers.

The pharmacy's website offered a range of treatments. People first selected a prescription medication before completing an online questionnaire on the website. The consultation or patient journey followed one of two processes depending on the condition being treated. This gave people the impression that they were likely to receive the treatment they had selected. And it could mean they may not receive the most appropriate treatment for their condition. Zava reviewed the completed online questionnaires. It only forwarded weight-loss prescriptions to the pharmacy. Zava sent prescriptions for all other medications to the Asda pharmacy at Patchway, Highwood Lane, Bristol.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's working practices are generally effective, which helps make sure people receive safe services. It gets its medicines from authorised suppliers and manages them appropriately to make sure they are in good condition and suitable to supply. The pharmacy team uses cold-chain packaging to maintain temperature-sensitive products during transit.

### Inspector's evidence

The main pharmacy was open Monday 8am to 11pm, Tuesday to Friday 7am to 11pm, and Saturday 7am to 10pm. It was also open on Sunday 10.30am to 4.30pm.

The pharmacy team prompted people to confirm the NHS repeat prescription medications they required, which helped the pharmacy limit medication wastage, and people received their medication on time. The pharmacy retained records of the requested prescriptions, so the team could effectively resolve queries if needed. The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including anti-coagulants, methotrexate, lithium, insulin, and valproate.

Pharmacy team members were aware of over-the-counter (OTC) medicines which were liable to misuse such as codeine-based pain relief medication. Team members had refused repeated requests for these medicines from the same people and advised them to consult their GP.

The team used colour-coded baskets during the dispensing process to separate people's medicines and organise its workload. Staff members permanently marked part-used medication stock cartons, which helped to select the correct medication quantity when dispensing and supplying medication.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. The team suitably secured CDs and it used destruction kits for denaturing unwanted CDs. The CD keys were secured appropriately. A record for who had possession of the CD key was maintained.

The main pharmacy and hub monitored its refrigerated medication storage temperatures. Records indicated that medicine stock in the main pharmacy and hub were regularly date checked. Randomly selected stock medicines each had a reasonably long shelf-life. The pharmacy kept prescription travel medicines as contingency stock for the online travel service at Asda pharmacy, Bristol Patchway because there had been some recent difficulties obtaining this stock.

The pharmacy team used an alpha-numeric system to store and retrieve prescriptions and bags of dispensed medication. This storage area was well organised, which assisted in finding people's medication.

The pharmacy had received some repeat requests for codeine-based pain relief medicines. Staff members refused these requests on the second occasion that these people presented, they signposted them to their GP, and the other team members were informed about these individuals. The pharmacy rarely sold codeine linctus.

The pharmacy took appropriate action when it received alerts for medicines suspected of not being fit for purpose and it kept supporting records. It had facilities in place to dispose of obsolete medicines,

and these were kept separate from stock.

The hub operated Monday to Friday 9am to 5pm assembling and dispatching any weight-loss prescriptions that it received from the online prescribing service. It also operated on Saturday 9am to 11am but it did not assemble weight-loss medicines that required cold storage as these needed to be dispatched and delivered within forty-eight hours, which was not possible during the weekend.

Zava prescribed weight-loss injections in quantities of one, three or five. It issued electronic prescriptions that included the prescriber's advance electronic signature. This helped the pharmacy to make sure each prescription was authentic. These prescriptions did not always include enough detail about the specific dosage directions that needed to be tailored to each patient. But the superintendent explained that the pharmacy could contact Zava to discuss dosages and any clinical issues.

The pharmacy kept a record that confirmed two team members had checked the quantity of injectable weight-loss products supplied to each patient. The team had a colour-coded system for marking injectable weight-loss prescriptions to confirm it had been supplied. However, these additional audit trails were not included in the pharmacy's written procedures.

The pharmacy had a written procedure for packing injectable weight-loss products that needed to be kept cold during delivery to people. It used cooling packs and insulated packaging that had been tested in transit to make sure these products were kept cold. The insulation maintained cold storage for forty-eight hours. The pharmacy used an external courier service who usually delivered injectable weight-loss products within twenty-four hours of leaving the pharmacy. So, the pharmacy had arrangements to make sure these products were transported at the appropriate temperature throughout the journey.

The pharmacy promptly reviewed prepared weight-loss products ready for dispatch if Zava urgently requested this. This was important because these requests usually involved a change to the prescribed medication.

Injectable weight-loss products were ready in their delivery packaging for dispatch from 10am onwards. The courier collected these packages at 4.15pm on weekdays. The pharmacy used the courier's track and trace service for delivering injectable weight-loss products. The pharmacy asked the patient to provide a date and time they would be at the destination address, and alternative arrangements for delivery if they were not there. The courier took a photo image at the destination address to confirm it had delivered each package. These arrangements helped to make sure safe and secure delivery of injectable weight-loss products. The pharmacy raised any concerns about deliveries with the courier. For example, leaving an injectable weight-loss product in the patient's wastepaper wheelie bin.

The courier left a note at the destination address if it could not hand over injectable weight-loss products packages personally. The pharmacy allowed the patient to collect their injectable weight-loss product from the courier's local collection centre up to forty-eight hours after dispatch. The superintendent pharmacist had clarified with the product manufacturer that the product was stable for thirty days after the patient started to use it. So, the pharmacy advised people to keep one injection and return the remainder to any Asda pharmacy, which helped to make sure they only used an injection that had been maintained under suitable conditions during transit.

Some people had sometimes experienced a delay in receiving their weight-loss medication due to the courier having an industrial dispute. The superintendent explained that Asda were exploring using other couriers to mitigate against this uncertainty.

The pharmacy sometimes received requests to replace weight-loss medicines. The team routinely requested the reason for re-supplying weight-loss products to people when Zava requested this. And

Zava issued another prescription to cover a replacement supply, although the pharmacy retained the final decision on whether to make a further supply. However, the pharmacy's written procedures did not clearly explain this process. The main reason for requesting a replacement was usually in relation to people reporting a faulty injectable product that needed to be returned to the manufacturer. People had to present these injections at an Asda pharmacy to verify the fault. This helped to make sure the reason for considering re-supplying the injection was genuine.

Post supply, the pharmacy signposted people who requested advice on how to self-administer their weight-loss injection to information on its website and online videos. It was suspected that most faulty injection reports were due to people using the injection incorrectly, and because the needle was easily susceptible to damage. This might have been avoided if the pharmacy had advised these people about the online videos before supplying the injection.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy team has the equipment and facilities that it needs for the services it provides. The equipment is appropriately maintained and used in a way that protects people's privacy.

### Inspector's evidence

Work surfaces, including those in the hub and consultation room, IT equipment and telephones were sanitised each working day, and records were kept. The staff kept the dispensary sink clean; it had hot and cold running water and antibacterial hand sanitiser was available. The hot water supply was checked daily to make sure it was available. The team had a range of clean measures. So, it had facilities to make sure it did not contaminate the medicines it handled, and it could accurately measure and give people their prescribed volume of medicine. Recent versions of the BNF and cBNF and BNF online were available to check pharmaceutical information if needed.

The pharmacy had facilities that protected peoples' confidentiality. It regularly backed up people's data on the PMR, which had password protection. So, it secured people's electronic information and it could retrieve their data if the PMR system failed. And the pharmacy had facilities to store people's medicines and their prescriptions securely.

### 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.