General Pharmaceutical Council

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: 17/01/2024

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 hypertension checks, emergency hormonal contraception (EHC), and it offers both NHS and private flu vaccinations. 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.

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

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 including weight loss treatments, 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 pharmacy had developed risk registers for medications supplied via prescriptions that Zava had issued through the online service, including weight loss products. These risk registers identified contingencies in the event of challenges preparing or supplying medication safely.

The superintendent pharmacist had sought assurance from Zava about the weight loss prescribing service to make sure it operated safely. The pharmacy had completed risk assessments which identified inclusion and exclusion criteria for the service, explained how information was shared with people's GP, and how the prescribing service verified the weight of the person requesting the medicine.

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 any patient safety issues 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 for injectable weight loss service issues. This helped the pharmacy to identify and manage risks in providing the service.

Pharmacy team members marked the medication name, strength, dose, and quantity on prepared prescriptions medicines to indicate these had been verified against the prescription. The dispenser and checker initialled dispensing labels for prescription medicines they prepared in the pharmacy, which helped to clarify who was responsible for each prescription medication supplied. This assisted with investigating and managing mistakes.

The pharmacy was subdivided into two areas each with its own team: the main pharmacy area with the front counter and dispensary, and the 'hub' where the weight loss products were assembled and dispatched. Pharmacy team members recorded and discussed mistakes they identified when dispensing medicines and they addressed each of these incidents as they arose. The main pharmacy and hub each kept a record of errors. A senior dispenser led weekly team reviews of mistakes from the main pharmacy, and both teams assessed the mistakes from the main pharmacy and hub at the end of each month. Records of these reviews included reasons why the mistakes had happened. This meant the pharmacy encouraged additional learning opportunities to identify trends and mitigate risks in the dispensing process.

The pharmacy had written complaint handling procedures, so staff members could effectively respond to any concerns. Publicly displayed leaflets included information on how people could make a complaint. The pharmacy had not completed a patient survey recently due to the pandemic.

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. People who suspected that they had a faulty weight loss injection had the option to return them to either the pharmacy or any Asda pharmacy where it was checked, and the pharmacists could provide additional advice to the patient on the correct use of the injection.

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, EHC consultations and the hypertension service that it provided.

Private prescription records generally contained the correct information. The prescriber's address was not always entered on the electronic private prescription record for supplied weight loss products, but the RP said they would rectify this. The pharmacy kept records for the medications prepared under a specials license or unlicensed medicines that it had supplied. But these did not always include the patient's details, so the team may have difficulties finding a record in the event of a query.

Staff members had completed training on information governance and protecting people's confidentiality. They signed a confidentiality agreement annually. They securely stored and destroyed confidential material. Each team member used their own security card and passwords to access NHS electronic patient data. The pharmacy team entered people's verbal consent to receive the NHS EHC and 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 prescriptions. But they were unable to locate any 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 RP and the other regular pharmacist 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 RP explained how the pharmacy routinely monitored for individuals who attempted to register more than one account for obtaining weight loss products by using different email addresses.

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 staff members present working in the main pharmacy included the RP and a dispenser. The staff members present working in the hub included three dispensers. And a dispenser worked between the main pharmacy and the hub. Other team members who were not on duty included a second permanent pharmacist, seven dispensers and a trainee dispenser. Seven locum pharmacists regularly provided cover.

The pharmacy had enough staff to comfortably manage the workload. There were two pharmacists simultaneously on duty for around seven hours per day for three days during the week. The trainee dispenser, who started working at the pharmacy in May 2023, had completed over two-thirds of their qualification course. All team members, including the RP, moved between the main pharmacy and hub according to workload. Both permanent pharmacists were flu vaccination and EHC service accredited, and six dispensers were flu vaccination accredited. These arrangements meant the team had the flexibility to make sure it managed the fluctuations in service demand throughout the course of the working day. The team usually had repeat prescription medicines and weight loss products, ready in good time for when people needed them. The pharmacy had a steady footfall. So, the team avoided sustained periods of increased workload pressure and it promptly served people.

The pharmacy manager, superintendent's office and Zava customer service teams had a joint meeting every two weeks to discuss the weight loss service’s operational performance, which included service quality and IT network issues. 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 met

Summary findings

The premises are clean, secure, and spacious enough for the pharmacy's services. And the pharmacy provides a professional environment for the delivery of healthcare services. The pharmacy's website contains information about the pharmacy and the associated prescribing service.

Inspector's evidence

The pharmacy’s level of cleanliness was appropriate for the services provided. It had the space needed to allow the team 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 and access was restricted to pharmacy team members only. Staff could secure the pharmacy premises.

The pharmacy's 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 online doctor service 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 condition or treatment area before completing an online questionnaire on the website. The website user navigated towards the questionnaire via one of three possible routes, which included information about the condition and the potential treatments. This helped to make sure people received the most appropriate treatment for their condition.

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 pharmacy operated 9am to 12.30pm, 1pm to 4.30pm and 5pm to 9pm Monday to Saturday. It was also open on Sunday 10.30am to 4.30pm. Information on the website signposted people to any Asda pharmacy or Zava about their prescription queries. The pharmacy's telephone number was provided on the website for any delivery queries.

The pharmacy team scheduled when to prompt 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. It had the advice booklets to give to methotrexate patients.

The team had recently checked for any people at risk who were prescribed valproate. It only supplied this medication sealed in the original packaging unless it was clinically appropriate to do otherwise as stated in Medicines Healthcare Regulatory Authority (MHRA) guidance. The pharmacy had the booklets which should be given to anyone receiving valproate for the first time, as stated under MHRA guidance. Valproate stock had the MHRA approved advice cards for people in the at-risk group attached. The pharmacy's written procedures explained how people at risk who were prescribed valproate should receive an annual specialist review, as required under the licence terms for valproate medicines.

The pharmacy team completed hypertension checks for people it suspected had an associated condition, symptoms or co-morbidity. The RP recalled examples of these checks that led to people referred to their GP and them being subsequently diagnosed with hypertension.

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, explored their symptoms which included establishing whether they had an acute or potentially chronic condition, suggested an alternative treatment, and advised them to consult their GP.

The team used colour-coded baskets in the main pharmacy 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 and short-dated stock quarantined two months before its expiry date.

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

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.

Zava reviewed the completed online questionnaires and made any additional checks before issuing prescriptions. Only weight loss prescriptions were forwarded to the pharmacy to supply. Prescriptions that Zava issued for all other medications were sent to the Asda pharmacy at Patchway, Highwood Lane, Bristol. The pharmacy kept prescription contraception, erectile dysfunction, travel, and period delay medicines as contingency stock in the rare event of disruption in the online service that Asda pharmacy, Bristol Patchway provided.

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.

The pharmacy only supplied medication if Zava had provided a corresponding prescription. Zava prescribed one month's supply of weight loss injections. It issued electronic prescriptions that included the prescriber's advance electronic signature. This helped the pharmacy to make sure each prescription was authentic.

The prescriptions that Zava issued included enough detail about the specific dosage directions that needed to be tailored to each patient. The RP explained that during the consultation phase Zava prescribers counselled their clients and signposted them to an online video which explained how they should self-administer their weight loss injection, which included the most suitable injection sites. The RP recalled that they had occasionally contacted Zava to discuss prescribed dosages or clinical issues and kept appropriate records of these conversations.

The team used colour-coded baskets to segregate the different weight loss prescriptions by medication strength. The pharmacy kept a record that confirmed two team members had checked the medication strength and quantity of injectable weight loss products and associated ancillary products supplied to each patient by referring to their prescription. The team had a colour-coded system for marking injectable weight loss prescriptions that corresponded to the livery colour on the weight loss product packaging, which helped to make sure people received the correct strength product. During the packing stage, a team member completed a final check of the client's name, weight loss injection product and delivery address on the postage label by referring to the prescription. Following a review, these additional processes and audit trails had been included in the pharmacy's written procedures.

The pharmacy had a written procedure for packing injectable weight loss products that required them 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 was usually due to a change to the prescribed medication or destination address.

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 when necessary.

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 product labelling informed patients that the injections were stable for six weeks after first use and how they should store them. These arrangements helped to make sure people only used an injection that had been maintained under suitable conditions during transit and while in their possession.

The pharmacy had procedures that addressed concerns from people who had not received their prescribed product. The team completed an incident report, which it shared with the superintendent's team. There was an agreed process to follow depending on whether the courier provided proof of delivery or not. And the pharmacy monitored these incidents for repeated issues which might raise a concern.

Post supply, the RP recalled counselling people who contacted the pharmacy for advice about how to administer their weight loss injection. The pharmacy also signposted people who requested advice on how to self-administer their weight loss injection to information on its website and online videos. The pharmacy supplied to people prescribed separate waste containers for the main body of the weight loss injection device and the needles, which people could return to any Asda pharmacy for safe disposal.

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.