General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Mill Street West, DEWSBURY, West Yorkshire, WF12 9AE

Pharmacy reference: 1091756

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

The pharmacy is in a 24-hour Asda supermarket in Dewsbury town centre. And it is open seven days a week. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). They provide treatments and vaccinations for various conditions, including meningitis, erectile dysfunction and seasonal flu. And they supply medicines to people in multi-compartment compliance packs. The pharmacy provides a substance misuse service, including supervised consumption.

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 has procedures to identify and manage risks to its services. It protects people's confidential information. And it adequately keeps the records it must by law. Pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen when dispensing. And they make changes to help reduce the risks. But they don't always record much detail about why mistakes happen. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The procedures were available electronically. The superintendent pharmacist's team reviewed the procedures every two years on a rolling cycle. Pharmacy team members were asked to read a selection of SOPs every month. They completed a quiz after reading each SOP to test their knowledge. And, if they successfully completed the quiz, an electronic record was made to confirm they had read and understood the procedure. The pharmacist said he would support and train pharmacy team members further if they failed a quiz to help improve and embed their understanding, before they reattempted the questions. Team members read all SOPs every two years or if there was an incident involving a procedure. The pharmacy defined the roles of the pharmacy team members in the SOPs. The pharmacist explained that the most popular service the pharmacy offered was the meningitis vaccinations service. The pharmacy had up-to-date, signed patient group direction (PGD) documents in place for the service. The pharmacist completed online training every two years before each new PGD was released. And he also completed physical vaccination administration training every two years. He had completed a visual risk assessment of the service to make sure the necessary equipment was in place. And to make sure the pharmacy's consultation room provided a suitable environment of the service. He had not documented the risks assessment.

The pharmacist highlighted near miss errors made by pharmacy team members when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. And their most common change after a mistake was to be more careful next time. The pharmacist analysed the data collected about mistakes each month. Pharmacy team members discussed the findings. His analysis was generally based on quantitative information, such as the number of strength or quantity error made. Or the medicines involved in the mistakes. He did not analyse the data for patterns of causes. In response to near miss errors, pharmacy team members had separated and highlighted some common look-alike and sound-alike (LASA) medicines on the shelves. For example, carbamazepine and carbimazole. Some of these medicines had been involved in errors. And they had highlighted others proactively to help prevent errors occurring. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system called PharmaPod. In the sample of records seen, pharmacy team members had recorded the details of each error. And they had given some information about the possible causes of the errors after they had been discussed with the team. The store's newspaper and magazine stand had moved from the foyer to the pharmacy waiting area. Pharmacy team members sold newspapers and magazines at the pharmacy counter and were asked questions, including whether they could refill the stand. These non-health related tasks and questions took the team members away from their pharmacy tasks. They had recorded these distractions as

contributory factors to mistakes that they had made, including two dispensing errors. They had highlighted this to the store manager and were awaiting a resolution.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. One example of recent feedback had been for the pharmacy to provide people with more advice about stopping smoking. In response, pharmacy team members had completed training about smoking cessation. And they explained they tried to more proactively engage people in conversations about smoking when they came to the pharmacy, especially when they accessed other services or requested to buy certain medicines.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records electronically. And these were mostly complete. But they frequently did not accurately record the date on the prescription if it was different from the date the medicines were supplied. They also recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It had a shredder available to destroy confidential waste. Pharmacy team members had been trained to protect privacy and confidentiality. They had completed online training on the subject and had read the most recent procedure. And they had signed confidentiality agreements. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said he would assess the concern. And would refer to the store manager and local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. All pharmacy team members trained in safeguarding every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They regularly complete training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services. Their suggestions are considered. And changes are made to help improve the way the pharmacy delivers its services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a dispenser and a medicines counter assistant. At least a pharmacist and one other pharmacy team member always staffed the pharmacy. Pharmacy team members completed training regularly using an online training portal called HeLo. The portal provided training modules about various subjects, including seasonal conditions, new products and professional pharmacy subjects. Some recent examples of topics included sepsis and cough and cold. They recorded their training and the pharmacist manager monitored their compliance. The pharmacy did not have an appraisal or performance review process. A dispenser explained he would raise any learning needs with the pharmacist informally. And they would support him to achieve his goals by teaching or signposting to appropriate resources.

The dispenser explained that he would raise professional concerns with the pharmacist, store manager or area manager. He said he felt comfortable raising a concern. And confident that his concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, bags of dispensed medicines had been filed in the pharmacy's retrieval area alphabetically by surname. And this had caused the shelves to become cluttered, especially when there were many people whose surnames began with the same letter. This meant prescriptions were difficult to find. And people had to wait longer for their prescriptions. They had discussed the issue. And reorganised the retrieval area. The pharmacy now stored prescriptions in numbered totes. Pharmacy team members placed the prescriptions bags in a tote. They wrote the corresponding tote number on the prescriptions. And filed the prescriptions alphabetically by surname. They explained this had made prescriptions much easier to find. And kept the shelves tidier and more organised. Pharmacy team members were asked to reach targets in various areas, for example prescription items dispensed and the number of medicine use reviews (MURs) and New Medicines Service (NMS) consultations completed. They were supported by their area manager to reach their goals.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet elsewhere in the store which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. The pharmacy has systems in place to help provide its services safely and effectively. It sources its medicines safely. And it stores and manages its medicines properly. Pharmacy team members take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely. They dispense medicines into devices to help people remember to take them correctly. And pharmacy team members generally manage this service well. But they don't regularly supply these people with written information to help them use their medicines effectively.

Inspector's evidence

The pharmacy had open-plan, level access from the rest of the store. It advertised services in various places in the retail area. Pharmacy team members explained they could provide large-print labels to help people with a visual impairment. And they would use written communication to help someone with a hearing impairment. Some pharmacy team members spoke Urdu and Punjabi, as well as English. And this helped them to communicate with most people in the local community.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. He checked if the person was aware of the risks if they became pregnant while taking the medicine. And checked if they were on a pregnancy prevention programme. He referred people to their GP if he had any issues or concerns. The pharmacy had a stock of printed information material to give to people to help them manage the risks. Pharmacy team members had audited their patients in 2019, to find people who regularly received valproate. The audit identified two people who were potentially at risk. The pharmacist contacted people and provided them with the necessary advice. Pharmacy team members packaged dispensed controlled drugs (CDs) and fridge items, such as insulin, in clear plastic bags. This meant they could perform a final visual check when the medicines were handed out. And they asked people to confirm they were receiving the expected product to help quickly resolve any queries or mistakes. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. And pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines. But only every six to twelve months. The pharmacy team documented any changes to medicines provided in packs on the patient's electronic record. And on their master record sheet.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines tidily on shelves. And it kept all stock in restricted areas of the premises where necessary. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training and procedures were in place to incorporate the necessary checks in to the dispensing process. Each compliant medicine pack was scanned during dispensing to check for falsified medicines. And to decommission the product from the supply chain. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinet tidy and well organised. And out of date and patient returned CDs were segregated. The inspector checked the

physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge, which was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment, and they stored all items 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.