General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Corporation Street, COLNE, Lancashire, BB8 8LU

Pharmacy reference: 1092279

Type of pharmacy: Community

Date of inspection: 22/05/2019

Pharmacy context

The pharmacy is in a 24-hour Asda supermarket on the outskirts of Colne town centre. And, it is open seven days a week. The pharmacy mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. And, it offers NHS services including medicines use reviews (MUR) and the New Medicines Service (NMS). Pharmacy team members provide a substance misuse service, including supervised consumption. And, they supply medicines in multi-compartmental compliance packs to people in their own homes. They provide medicines for malaria prevention, erectile dysfunction and period delay via patient group directions (PGD). And, they provide seasonal flu vaccinations.

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 up to date procedures to identify and manage risks to its services. It has an audit of key governance and safety tasks. But, when team members complete the audit they don't always identify areas where they need to make improvements. The pharmacy mostly maintains the records it must by law. And it has systems in place to manage complaints and people can give feedback about its services. It listens to the feedback and makes changes where it can to improve services for people. The pharmacy team members read and follow the procedures. They complete regular training, so they know how to keep people's information secure. And they understand how important their role is in keeping people's information safe. They know what to do to protect the welfare of a child or vulnerable adult if there is a concern.

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 had implemented the procedures sampled in 2018 and 2019. And had scheduled the next review of the procedures for 2020 and 2021. 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. Pharmacy team members were given three attempts to pass an SOP quiz. The pharmacist said they would be supported and trained 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 highlighted near miss errors made by the pharmacy team when dispensing and recorded the mistakes. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. A dispenser said they were usually told what they had done wrong and how they could improve by the pharmacist. But, they said they were also able to contribute ideas about how to prevent the mistake happening again if they wanted to. The pharmacist analysed the data collected about mistakes every week. And, a further analysis was carried out at the end of each month. Pharmacy team members discussed the findings. Some records of recent analysis were available. But, there was no analysis to find patterns of causes of mistakes. In response to near miss errors, pharmacy team members had separated medicines with similar names and packaging to help prevent mistakes when selecting medicines. And, they had attached warning labels to the edges of drawers in front of medicines that had been involved in a mistake. 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 PDIS. In the records seen, the team had recorded comprehensive information about what had gone wrong, why and what had been done to prevent the error happening again. And, steps taken to prevent a future error were visible in the pharmacy.

The pharmacy completed a weekly compliance checklist. It assessed various areas, including data protection, patient safety and controlled drugs (CD) management. For example, whether CD registers

were being audited weekly, whether near miss errors were being recorded, whether pharmacy team members had their own NHS smart cards and whether they were sharing smart cards. The pharmacy had the latest checklist available from the 11 May 2019. Pharmacy team members had recorded that no action was required because all staff had their own smart cards and were not sharing cards that belonged to others. But, during the inspection, a dispenser was seen using the pharmacist's card. The dispenser said she had her own card. But, when she tried to use it, the card had expired, indicating it had not been used for some time. The other member of dispensing staff present did not have her own smart card. Recent records of weekly checks were available from before the 11 May 2019 and did not document any issues with pharmacy smart card use, despite the issues highlighted above.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. And, it had some analysis from the last set of questionnaires analysed. One improvement point was having the right stock available. The pharmacist explained that the company were encouraging teams to reduce the amount of stock on the shelves. He said the team were looking at balancing this with the stock they used regularly, to make sure they kept the right quantity of medicines that people regularly needed.

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. They kept private prescription records electronically, which were 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 in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy team had been trained to protect privacy and confidentiality. They had completed online training on the subject and had read the most recent procedure. 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 they would assess the concern. And would refer to local safeguarding teams and head office for advice. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members were regularly trained. And, the pharmacists had completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified and have the right skills for their roles and the services they provide. They undertake training regularly. But, they don't have an opportunity to formally discuss their performance or individual training needs. So, it may be difficult to tailor the learning to the individual. The pharmacy team members feel able to raise concerns and use their judgement. They can discuss issues and act on ideas to support the delivery of services. But they don't always establish and discuss specific causes of mistakes. So, they may miss chances to learn from errors and make changes to make things safer.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a dispenser, a trainee dispenser and two medicines counter assistants. 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. They recorded their training and the pharmacist manager monitored their compliance. The pharmacy did not have an appraisal or performance review process. A dispenser said that any needs she had would be discussed with the pharmacist informally and they would support her to achieve her goals.

A dispenser explained she would raise professional concerns with the pharmacist, store manager, area manager or superintendent pharmacist's office. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy and pharmacy team members were clear about how to access the procedure.

The pharmacy team communicated with an open working dialogue during the inspection. A dispenser said they were told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why they had made the mistake. But, they said they would always try and change something to prevent the mistake happening again, such as moving products on shelves or attaching stickers to shelves to highlight risks.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They said they had changed the way the prescription retrieval area was organised after receiving a communication from head office. The system had been changed from prescriptions being stored alphabetically on shelves to using numbered trays. They said they ow found prescriptions easier and quicker to find.

Pharmacy team members were asked to reach targets in various areas, for example prescription items dispensed and number of medicine use reviews completed. They said they had always met targets and were unsure what would happen if a target was not met. But, they were confident that they would be given support by head office to improve to help reach a target.

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 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. The pharmacy team 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 WC 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 is accessible to people, including people using wheelchairs. And it provides its services safely and effectively. It stores, sources and manages its medicines safely. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. But, they do not regularly provide these people with medicines information leaflets. They take some steps to identify people taking high-risk medicines and provide them with appropriate advice. But the team don't have any written information for people to take away. So, people may not have all the information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from car park through automatic doors. Pharmacy team members could provide large print labels and instruction sheets to help people with a visual impairment. And, the gave an example of a compliance pack they provided with large print information. The pharmacy had a hearing induction loop to help people with a hearing impairment. Some pharmacy team members spoke Urdu and Punjabi as well as English. They explained that this enabled them to communicate with most people who used the pharmacy.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It included descriptions of the medicines supplied on the packaging, to help people identify their medicines. But, it did not regularly provide people with patient information leaflets about their medicines. The pharmacy team documented any changes to medicines provided in packs on the patient's master record. But, they did not record who had implemented the change, when, or who had acted in the pharmacy to change the pack.

A medicines counter assistant gave a clear explanation of the protocols in place to make sure over-the-counter medicines were provided to people safely. They gave examples of restricting the quantity of co-codamol and pseudoephedrine they would supply. And they gave examples of requests for certain products they would immediately refer to the pharmacist.

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 people's prescriptions being mixed up. They stored dispensed controlled drugs (CD) and fridge items in clear plastic bags to facilitate a further check of the product against the prescription by pharmacy team members as the item was handed out. But, they did not ask the patient to confirm if it was the product they were expecting. The pharmacist counselled people receiving prescriptions for sodium valproate if appropriate. And, he said he would check if they were aware of the risks to pregnancy while taking the medicine. He said he would also check if they were on a pregnancy prevention programme. But, the pharmacy did not have any printed information material to give to people or any material to help highlight the medicine or manage the risks during the dispensing process.

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 two months before their

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. The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including CDs. The pharmacy team 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 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 were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training. But, they did not know if procedures had been changed to accommodate the process. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. The pharmacy had installed new product scanners. But, pharmacy team members did not know of any software to use to scan products. And they were not currently incorporating the requirements of FMD in to the dispensing process.

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 team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it shredded confidential waste. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored 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.