General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Leeds Road, Glasshoughton, CASTLEFORD, West Yorkshire, WF10 5EL

Pharmacy reference: 1096721

Type of pharmacy: Community

Date of inspection: 11/06/2019

Pharmacy context

The pharmacy is in an Asda supermarket in Glasshoughton, close to Castleford. The pharmacy dispenses NHS and private prescription. And it provides medication in multi-compartmental compliance packs to help people take their medication. The pharmacy provides flu vaccination services, malaria prophylaxis medicines and medication to delay periods. The pharmacy also provides a needle exchange service. And it holds palliative care medicines for use in an emergency.

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

The pharmacy identifies and manages the risks associated with its services. And it generally keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has suitable arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

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 team read the SOPs and completed a test to show their understanding. The resident pharmacists monitored completion of this for each member of the team. And displayed a list of team members that still had to complete the SOPs. 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 errors. The team member involved was responsible for recording the error. A sample of error records looked at found that the team usually 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 resident pharmacists reviewed these records each month to spot patterns and make changes to processes. And shared the outcome of the review with all the team.

The pharmacy team recorded dispensing incidents electronically and shared them with the team. The team printed off the report and kept it with any packaging involved with the error. The pharmacy sent the reports to head office who replied with suggestions and actions to prevent the same mistake from happening. The pharmacists recorded the error in the team's communication book for everyone to see. One report captured an error when a team member had put incorrect dose instructions on to a label. The report captured the causes as the team member was distracted and had misread the prescription, which led to a typing error. The report explained that the team member involved had been retrained on the relevant SOP and was to take a mental break when busy. The team member involved had signed a copy of the SOP to show they had re-read it. The team put a note on the patient medication record (PMR) to alert all the team to this error. And to prevent the same mistake happening again to this person.

The pharmacy undertook a monthly patient safety review to identify patterns with all errors and the actions taken to prevent the same mistakes. The March 2019 review highlighted errors linked to the team not concentrating when counting out medicines and not reading the prescription accurately, especially during busy periods. The review stated that the team was to double count medicines, especially CD prescriptions, and to separate medicines often involved with errors. The pharmacy

completed weekly internal compliance checks. These included tasks such as getting an NHS smart card for the trainee dispenser.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet 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 mostly legal requirements. The headers in some registers were not completed. 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 emergency supply requests met legal requirements. The pharmacy kept an electronic record of supplies of medicines from private prescriptions. A sample of these records looked at found that on one occasion the prescribers name was not correct. 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 pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and team members had access to contact numbers for local safeguarding teams. The regular pharmacists had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017 and had refresher training in 2018. The team had not had the occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to support the pharmacy's services. And they share information and learning particularly from errors when dispensing. The pharmacy team members have many opportunities to complete more training. But not all the team members receive feedback on their performance. So, they may miss the opportunity to reflect and identify training needs. And progress in their role or take on a new role to help the safe and effective delivery of services. The team members discuss how they can make improvements. And they agree new processes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

Two resident pharmacists covered most of the pharmacy opening hours. Locum pharmacists provided support for the remaining hours. The resident pharmacists split the managerial tasks between them and had some overlap time each week. This gave time to share events and discuss tasks they needed to complete. The pharmacy team consisted of four qualified dispensers, and three trainee dispensers. Two of the trainee dispensers included pharmacy busters who previously worked in other areas of the store and supported the team when required. The pharmacy busters had received medicine counter assistant training. And had a regular day in the pharmacy to help maintain their knowledge and skills. The pharmacy had just enrolled a new pharmacy buster on to the medicines counter assistant course (MCA). Another pharmacy buster new to the team was to also be enrolled. The pharmacy had recruited these two pharmacy busters to fill the gap on a Wednesday morning. The pharmacy displayed the team's training certificates. At the time of the inspection there was one of the resident pharmacists, two qualified dispensers and a trainee dispenser. The team wore name badges detailing their role.

The pharmacy provided additional training through online modules. Recent training included the legal changes to gabapentin and pregabalin products and allergies. The pharmacy team members had their own log in and could see what training they needed to do. The team members could also see how they were progressing with their training. The team usually used quieter times such as early morning or evening shifts to do the training. The resident pharmacists monitored completion of the training. A note by the dispensary computer listed which team members were still to complete the training. The team could access previous training modules if they wanted to refresh their knowledge. The team read the newsletter from head office and signed to show they had done this.

The resident pharmacists 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 didn't offer team members opportunities to do further qualifications such as NVQ3. The resident pharmacists gave informal feedback to the team and supported team members with their training.

The pharmacy didn't have formal meetings as team members worked different shifts. The resident pharmacists shared key pieces of information with team members when they were on duty. The pharmacy had a communications book to record information for all the team to be aware of. The pharmacy team read the book at the start of their shift to make sure they were up to date. Team members could suggest changes to processes or new ideas of working. The team had rearranged the

storage of stock to make date checking easier. And one of the resident pharmacists had created a date checking rota. This ensured that all team members were involved and that the date checking was completed. The resident pharmacists had discussed with the store management the Asda policy of all teams working in different sections of the supermarket. The pharmacists raised concerns that moving team members from the pharmacy could affect the safe delivery of pharmacy services. So, this policy was not applied to the pharmacy team.

The pharmacy had targets for its services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacists offered the services when they would benefit people. This included people on long term inhalers. The pharmacist checked their inhaler technique and advised the person how to prevent oral thrush when using inhalers.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. And it has appropriate arrangements for people to have private conversations with the team. The pharmacy environment is not always suitable for the team to work in.

Inspector's evidence

The pharmacy was close to the entrance of the supermarket and it did not have a low level ceiling to keep the heat in. At the time of the inspection the pharmacy was cold. The team had a very small heater and were wearing fleece jackets to keep warm. The team members explained that in winter the pharmacy was very cold, and they often had to wear fingerless gloves as well as extra layers. The team had raised this with senior management within the company. This had led to discussions on how to resolve this but to date no action had been taken.

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink. The pharmacy displayed notices describing effective hand washing techniques next to the sinks. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The team kept the medicine waste bin and used needle bin in the consultation room. There was no space in the dispensary to store these bins. The team ensured the bins were never full and they were regularly removed for disposal.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people.

The premises were secure. The pharmacy 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 provides services that support people's health needs. The pharmacy manages its services well. It has appropriate systems to support the safe supply of medication in multi-compartmental compliance packs. The pharmacy gets is medicines from reputable sources. And it has suitable arrangements to store and manage medicines.

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 had a list of local NHS walk-in centres to pass on to people. The team had produced this after receiving many requests from people needing access to medical treatment especially at weekends and in the evenings. The pharmacy kept a small range of healthcare information leaflets for people to read or take away.

One of the dispensers was the healthy living pharmacy champion responsible for organising campaigns to raise people’s awareness of healthy living messages. The current campaign focused on children’s oral health. The dispenser had created an eye-catching display including guidance about toothbrush use for children. The team took the opportunity of interactions with parents or when a prescription had a product related to oral health, to hand over the guidance. The team had seen an increase in people asking for advice and sales of smoking cessation products during the Stoptober campaign.

The services for flu vaccination, malaria prophylaxis medication and the period delay medicine were provided against up to date patient group directions (PGDs). These gave the pharmacists the legal authority to provide these services. The pharmacy held a range of palliative care medicines. And regularly checked stock levels to ensure the items were available. So, the person receiving end of life care was not left without their medicines.

The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The checks had revealed one person who met the criteria who the pharmacists spoke to. The team added a note to the patient medication record (PMR) to remind the team to have a safety conversation with the person. The pharmacy had the PPP pack containing information to hand over to people when required.

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. Occasionally the pharmacist had to dispense and check their own work. On these occasions the pharmacist informed the person that it would take slightly longer to process the prescription. The pharmacist incorporated a break between dispensing and checking. This helped to identify any errors.

The pharmacy provided multi-compartmental compliance packs to help seven people take their

medicines. The team was setting up the service for two other people. The team spent time with people new to the service explaining how to use the packs. The pharmacist also assessed if the person was suitable for the service. Or, if the team could offer alternate support. The pharmacist asked the person what time they took their medicines to ensure the packs matched this. One of the qualified dispensers managed the service. And got support from others in the team. The team members ordered and received the prescriptions in advance. This gave them time to deal with issues such as missing items. And the dispensing of the medication in to the packs. 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 dispenser used a section of the dispensary away from the distractions of the pharmacy counter to dispense the medication. The team knew to not disturb the dispenser when she was dispensing the medicines into the packs. The dispenser recorded the descriptions of the products within the packs to help people identify the medicines. When there were several white tablets in the pack the dispenser also recorded whether the tablet was small, medium or large. The pharmacy supplied the manufacturer's patient information leaflets with the packs. The team members received copies of hospital discharge summaries that they checked for changes.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy team stored the prepared daily doses in the controlled drugs cabinet with the prescription attached. This acted as a prompt to check the dose before handing it to the person. And to reduce the risk of selecting the wrong one. The pharmacy stored doses for the person to take away in a bag with the prescription attached. 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 CD prescriptions were within the 28-day legal limit before making the supply. 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 it used the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was in May 2019. The team used a highlighter pen to mark medicines with a short expiry date. And it kept a list of products due to expire each month. 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 trazadone liquid with one month's use once opened had a date of opening of 7 June 2019 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 procedures and equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team members had received training but they were not scanning products. The pharmacy obtained medication from reputable sources such as AAH. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via an internal email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and 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 team used a separate, marked counting triangle for cytotoxic medication such as methotrexate. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to peoples' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computer in a way to prevent disclosure of confidential information. The team kept the computer in the consultation room switched off when it was not in use. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.