General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Howley Park Road, Morley, LEEDS, West Yorkshire, LS27 0BP

Pharmacy reference: 1097385

Type of pharmacy: Community

Date of inspection: 11/02/2020

Pharmacy context

This community pharmacy is in an Asda supermarket. The pharmacy dispenses NHS and private prescriptions. And it supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy provides the seasonal flu vaccination service, malaria prophylaxis medicines and medication to delay periods. And it provides a supervised methadone consumption service. The pharmacy offers the community pharmacist consultation service (CPCS).

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	1.2	Good practice	The pharmacy team members respond competently when errors happen. All the team members are informed when errors happen, and they share learning. They record their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
2. Staff	Standards met	2.5	Good practice	The pharmacy encourages the team members to share ideas on how to improve the delivery of services. And they provide feedback to the company when changes are introduced. The team members introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. The pharmacy team members respond competently when errors happen. They record their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy has arrangements to protect people's private information. And people using the pharmacy can raise concerns and provide feedback. The pharmacy keeps the records it needs to by law.

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 kept the SOPs electronically. The team members accessed the SOPs and answered a few questions to confirm they had read and understood the SOPs. Each team member had their own password to access the SOPs and other training modules. The pharmacist manager received alerts about new SOPs or changes via an internal notification system. 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 error. The pharmacy kept records of these near miss errors. And the team member involved recorded their own error. The team had attended a patient safety training event about common dispensing errors and how to prevent them. A sample of near miss 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 their thoughts on what caused the error and the actions they had taken to prevent the error happening again. The pharmacist manager reviewed the near miss records each week to spot patterns and make changes to processes. The pharmacy recorded dispensing incidents electronically and shared them with the team. These were errors identified after the person had received their medicines. The team discussed the incident and recorded the incident on the person's electronic medication record (PMR). The team also recorded the incident in the team's communication book. So, all team members were aware of the error. After an incident when a prescription for methadone was reported as missing the pharmacist manager spoke to the team and locum pharmacists. And asked all pharmacists to ensure, after the making the supply to the patient, that the prescription was placed in the correct wallet in the dedicated folder used for these prescriptions.

The pharmacist manager completed monthly patient safety reviews and shared the results with the team. Recent reviews had reminded the team members to avoid distractions when dispensing, to read the prescription carefully and to double check the items they had dispensed before handing it to the pharmacist for the final check. The team placed stickers on to the shelves holding medicines that looked and sounded alike (LASA). And displayed a poster in the dispensary listing common LASA medicines. For example, quinine and quetiapine. The stickers highlighted to the team members the risk with LASA medicines and prompted them to check the medicine picked when dispensing. The team had separated the different strengths of Malarone after identifying that the packs were similar in appearance.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it

had a leaflet and a poster 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. The latest survey included positive comments about the cleanliness of the pharmacy. The survey highlighted comments for improvement from people about team members answering queries raised by people. The survey results indicated that the team were provided with additional training to be able to answer people's queries or to refer the query to the pharmacist.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly 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 private prescription supplies, and emergency supply requests met legal requirements. 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 team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding procedure and team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed internal safeguarding training and Dementia Friends training. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And to provide training to people new to the company. The team members support each other in their day-to-day work. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives some team members regular feedback on their performance. The pharmacy encourages the team members to share ideas on how to improve the efficient delivery of services. And supports team members to make changes to improve the safe delivery of these services.

Inspector's evidence

One full-time pharmacist manager covered some of the opening hours. Regular locum pharmacists provided cover for the remaining hours. The pharmacy team consisted of two part-time qualified dispensers, a trainee part-time dispenser, a recently qualified part-time medicines counter assistant (MCA) due to start the dispensing course, and a new part-time member of the team who started a few weeks before the inspection and was about to enrol on to the MCA course. The pharmacy displayed the team's training certificates in the consultation room for people to see. At the time of the inspection the pharmacist manager, one of the dispensers and the new starter were on duty.

The pharmacists sometimes worked without a dispenser. On the rare occasion a person presented a prescription during this time the pharmacist incorporated a mental break between dispensing and checking their own work. And the pharmacist and MCA on duty informed the person presenting the prescription that there would be a longer waiting time. So, the person could choose to wait or return to the pharmacy.

The pharmacy was a training academy for pharmacists new to the company. And for senior team members from other departments that had contact with the pharmacy team. The pharmacist manager provided the training and feedback to the trainees. The team at Asda head office also used the pharmacy to try new procedures or systems. And to provide feedback to the team at Asda head office. The pharmacy provided extra training through e-learning modules. The pharmacist manager received notification of new training modules and the dates when the team had to complete the training. So, the pharmacist manager could plan with the team when to complete the training. The pharmacy team members had their own log in and could see what training they needed to do. The team members and the pharmacist manager could see how they were progressing with their training. And the team had some protected time to complete the training. The team printed off and read the newsletter sent from the pharmacy team Asda head office. The latest newsletter informed the pharmacy team that an increase in the number of multi-compartment compliance packs supplied across the company had seen an increase in near miss errors. So, all teams were reminded to be extra careful when dispensing and checking these packs. The pharmacist manager 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 pharmacist manager gave the team informal, in the moment, feedback.

The pharmacy didn't have formal meetings as team members worked different shifts. The pharmacist manager 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. And the team members read the book at the start of their shift to make sure they were up to date. Information captured in the communication book included the results from near miss reviews. And details of dispensing incidents and the actions taken to prevent the incident happening again. The pharmacy also used a WhatsApp group to ensure all team members were kept up-to-date with information. Such as the release of new training modules and to ask team members to do extra hours. The information shared on the WhatsApp did not include any confidential information.

Team members could suggest changes to processes or new ideas of working. One of the team suggested using a separate form to record changes to people's medicines who received multi-compartment compliance packs. This had been implemented and the pharmacist manager had shared it with the pharmacy team at head office. The form was introduced to other Asda pharmacies and the company procedures were updated to reflect this. The pharmacist manager had created an audit trail of when the different stages of preparing the packs were completed. So, all the team members were aware. The pharmacy had targets for services and the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It has limited working space. The team manage the space so it is suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The dispensary was small with limited working space. The team managed this by keeping the dispensary work benches free of clutter. The team kept floor spaces clear to reduce the risk of trip hazards. 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 and alcohol gel for hand cleansing. The pharmacy displayed notices describing effective hand washing techniques next to the sinks.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. And the pharmacists invited people in to the consultation room to take their methadone doses. The premises were secure. The pharmacy had 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 team members provide services that support people's health needs. And they manage the pharmacy services well. The team members seek to identify issues that may affect the safe and effective delivery of services. And they pro-actively act to address them. The pharmacy team members have good systems to manage the supply of multi-compartment compliance packs to people. So, they can provide the service safely and efficiently. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines well.

Inspector's evidence

People accessed the pharmacy via the store entrance. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy displayed a poster in the retail area providing people with information about the Coronavirus. The team wore name badges. The pharmacy had up-to-date patient group directions (PGDs). These gave the pharmacists the legal authority to provide the services such as the flu vaccinations and the supply of malaria prophylaxis medicines. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in individual bags with the prescription attached. To reduce the risk of selecting the wrong one.

The pharmacy provided multi-compartment compliance packs to help around 12 people take their medicines. The pharmacist manager spoke to the person due to receive the packs and to their carer to ensure the service was appropriate for the person. The pharmacist asked the person when they usually took their medicines. So, the team members could ensure they placed the medicines in the correct time slot especially for medicines prescribed as once a day. The pharmacist completed an assessment form after speaking to the person. The team kept a sheet listing all the packs due each week. The list showed completed packs and those not completed including details of why they were incomplete. This information included missing prescriptions and the date the prescription was expected. So, all the team, especially the team members working on a Sunday who usually prepared the packs, were aware. The team usually ordered prescriptions one week before supply. This allowed 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 and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team kept the medication list, the assessment form and any other information in wallets labelled with the person’s name in a dedicated folder. The team picked the stock before dispensing so they knew what medicines had to be ordered. The team members usually dispensed and checked the packs on a Sunday when they were less busy with other jobs. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. After checking the packs, the pharmacist bagged the packs separately with the prescription attached. The team stored completed packs separate from other prescriptions awaiting collection. So, the team could check that people were collecting their packs. And take appropriate action when people did not collect their packs. The hospitals contacted the pharmacy to inform the team when people using the packs were admitted in to hospital. The team stored the person’s packs in a separate section with a note indicating the person was in hospital. The pharmacy received copies of the person's hospital discharge summary. The team checked the discharge summary for changes or new

items. And requested prescriptions from the GP team when required. The team kept the discharge summary to refer to if query arose. The team kept a separate record of communications about the person's medication such as requests from the GP to change the person's medicine. So, the team could easily find this information when queries arose.

The team members provided a repeat prescription ordering service. The team asked people to contact the pharmacy to order their medicines or drop off the repeat prescription slip five days before they needed the next supply. This gave time for the team to chase up missing prescriptions, order stock and dispense the prescription. The team members kept a record of the requests. This included the date they requested the prescriptions and the medicines ordered. The team regularly checked the record to identify missing prescriptions and medicines and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had completed regular audits of the supply of valproate to check if anyone met the criteria. The audits found one person prescribed valproate who met the PPP criteria and was on a PPP. The pharmacy had the PPP pack to provide people with information when required. And it displayed a PPP poster in the dispensary to remind the team of the criteria. The team completed checks with other people taking high-risk medicines. And recorded details of the conversations with people on to the person's electronic medication record (PMR).

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. The team members used this as a prompt to check what they had picked. The pharmacy team used a patient record form to alert the pharmacist to information about the prescription or person obtained from the PMR during labelling. These forms included dose changes or new medication. The team also used post-it notes to share this information with the pharmacist. 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 supplies of CD prescriptions were within the 28-day legal limit. 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 kept a separate one with 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 on 04 February 2020. The team used a large yellow sticker with the expiry date written on to highlight medicines with a short expiry date. 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 cetirizine oral solution with six months use once opened had a date of opening of 25 October 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy team kept the stock in the fridge tidy. And separated stock from completed prescriptions awaiting supply. 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. And promptly destroyed CDs returned by people.

The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team were scanning FMD compliant medicines. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the internal system or directly from the MHRA in an email. The pharmacist manager also received the alerts on their personal phone. 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 the team mostly uses the pharmacy's facilities and equipment in a way to 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 measures for methadone and separate cylinders for measuring water when preparing liquid antibiotics. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. And it kept the computer screen in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary which had restricted access. A few empty bottles used to provide people with their methadone doses were found in a medicine waste bin in the consultation room. These still had the dispensing labels attached. The door into the consultation room from the retail area was locked. The pharmacist manager showed the medicine waste bin in the dispensary specifically used for these bottles which contained many of these empty bottles. The pharmacist manager stated he would attach a note to the bins to ensure all pharmacists knew where to put these empty bottles.

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.