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: 30/01/2024

Pharmacy context

This pharmacy is in an Asda supermarket near to Morley, a large town in West Yorkshire. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides a few people with their medicines in multi-compartment compliance packs to help them take their medication properly. The pharmacy provides other NHS services including the hypertension case finding service. And the NHS community pharmacist consultation service.

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 well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it generally keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns. The team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of the pharmacy's services. Team members accessed the SOPs through personal log in details. And completed a quiz connected to each SOP to show they had read, understood and would follow the SOP. Team members could see when new SOPs were sent and how they were progressing with reading the SOPs. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacists asked team members to correct mistakes found at the final check of a prescription. Records of these errors, known as near misses, were kept and the team member involved usually completed them. Occasionally the pharmacist completed the record on behalf of the team member but would discuss the error with them when they were next on duty. So, they were aware of their error and could learn from it. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident, and they discussed how to prevent such errors from happening. The pharmacists regularly reviewed the near miss records and dispensing incident reports. The outcome from the review was shared with team members who discussed the actions they could take to prevent errors from reoccurring. One team member had highlighted to the team the importance of checking the dispensing label against the information on the medicine's packaging to ensure they matched. This was in addition to checking the dispensed medication against the information on the prescription. Another team member had introduced a process of highlighting the strength prescribed when a medicine was available in more than one strength. Which prompted team members to double check the strength they had selected. Team members reported since adopting these processes there had been a reduction in errors. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. A poster displayed by the pharmacy counter provided people with information on how to raise a concern. The company website provided information on how to provide feedback. And comments left on social media platforms were monitored to ensure appropriate responses were provided.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. Appropriate records were kept of CDs returned by people for destruction which were promptly destroyed. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. And a random balance check undertaken during the inspection was correct. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. A separate notice informed people when the pharmacist was away from the pharmacy as they were taking a break. And team member knew what activities could and could not

take place in the absence of the RP. In preparation for the launch of the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. However, the PGDs had not been signed by pharmacists to show they had read them, understood them and would follow them.

Team members knew how to manage people's confidential information and the pharmacy displayed a notice advising how it protected people's private information. The team separated confidential waste for shredding offsite. The pharmacy provided the team with safeguarding training and guidance. And team members had completed training relevant to their roles. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They have some opportunities to receive feedback and complete training so they can suitably develop their knowledge.

Inspector's evidence

The pharmacy employed two full-time pharmacists with managerial responsibilities and locum pharmacists provided cover for the remaining hours. The pharmacy team consisted of five part-time dispensers and one part-time trainee medicine counter assistant (MCA). A team rota provided some overlap time for team members, except for the pharmacists. This supported team members to complete tasks such as putting stock away, which was particularly helpful to ensure benches were promptly cleared for them to work from. At the time of the inspection one of the regular locum pharmacists and two of the dispensers were on duty.

Team members worked well together and knew how to undertake key tasks such as checking medicine expiry dates, which was allocated to different team members each month. This ensured these tasks were completed regularly, including times when team numbers were reduced such as planned and unplanned absence. The pharmacy held weekly team meetings usually on a day when all team members were present, and all key pieces of information such as new services were shared. They also used a communication platform and a communications book to record information for all team members to be aware of.

The pharmacy provided extra training to team members through e-learning modules. The team read the newsletter regularly sent from the Superintendent Pharmacist’s team which provided information such as changes to legislation. In preparation for the launch of the NHS Pharmacy First service the team had received a new set of SOPs and training modules. And the pharmacists had completed additional training reflecting their specific roles such as assessing the conditions listed within the service. The company had also produced a Pharmacy First toolkit for team members to refer to. Team members did not receive formal feedback on their performance but regularly received informal feedback from the pharmacist manager and store managers. However, there was limited opportunities for team members to develop their skills and undertake further qualifications.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. It has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy, in particular the dispensary, was small with limited working space. Team members worked in a tidy and organised manner, and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy was clean and hygienic, and there was hot and cold water along with alcohol gel for team members to clean their hands. The pharmacy had a defined professional area and items for sale in this area were healthcare related.

The pharmacy had a soundproof consultation room which the team used for private conversations with people and when providing services. The team kept the room tidy and the door from the retail area was locked when not in use to prevent unauthorised public access. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people and opportunities are taken to raise awareness of the services. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via the supermarket entrance through an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. Information about the pharmacy including its opening hours was also displayed for people to read. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the correct product was supplied. And they knew when to refer requests to the pharmacist. The NHS community pharmacist consultation service was popular especially at weekends when referrals came from NHS 111. The NHS hypertension case finding service was popular and had resulted in some people being referred for further tests. Team members promoted the service to people and knew who would qualify so they could provide information about the service. And invite them to use the service. The team had also put notices in the staff areas of the supermarket to raise awareness of the service.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. Prescriptions were requested several days before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication, dosage and dose times and this was referred to throughout the dispensing and checking of the packs. The team recorded the descriptions of the medicines within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about the medicines they were taking. Team members usually dispensed and checked the packs on a weekend when they were less busy with other tasks. The team received copies of hospital discharge summaries sent via the NHS communication platform. These were checked for any changes or new medicines, and the person's records that were kept in the pharmacy were updated.

The pharmacy supplied some medicines as supervised doses which were prepared the evening before supply to reduce the workload pressure of dispensing at the time of supply. The prepared doses were stored securely and people's doses separated to reduce the risk of selecting the wrong one. The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the new rules requiring valproate to be supplied in the manufacturer's original outer packaging. Team members could not recall if a review of people prescribed valproate had taken place to identify anyone who may meet the PPP criteria. But they reported no-one prescribed valproate at the time of the inspection met the criteria.

Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and

‘checked by’ boxes on dispensing labels, to record their actions in the dispensing process. Team members used clear bags to hold dispensed CDs and fridge medicines which allowed them, and the person collecting the medication, to check the supply. The pharmacy had a system to ensure prescriptions with CDs were supplied within the 28-day legal limit. When the pharmacy didn’t have enough stock of someone’s medicine, it provided a printed slip detailing the owed item. The pharmacy sent people a text message to advise them when their prescription was ready to collect. This helped to ensure people received their medication when they needed it.

The pharmacy obtained medication from reputable sources. Team members checked the expiry dates on stock and marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines remained safe to use. The dates the opened medication should be used by were also recorded. The team checked and recorded fridge temperatures each day and a sample of these records were within the correct range. CDs were stored securely and out-of-date CDs were separated and clearly marked. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the company’s internal communication platform. The team responded appropriately to these alerts and kept a record of their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And a fridge for holding medicines requiring storage at this temperature. The pharmacy completed safety checks on the electrical equipment. And equipment such as the blood pressure monitor was replaced annually to ensure accurate readings were taken.

The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.