General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Spring Street, BURY, Lancashire, BL9 0RN

Pharmacy reference: 1107785

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

The pharmacy is in an Asda supermarket on the edge of the town centre. And it is open 100 hours over seven days. It dispenses NHS and private prescriptions. And the pharmacy collects people's prescriptions from local surgeries which are not available to be sent electronically. It provides private services using patient group directives (PGDs) for its malaria prevention, erectile dysfunction treatment, hair loss treatment and period delay services. The pharmacy team completes blood pressure checks. It offers a seasonal flu vaccination service.

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	1.2	Good practice	The pharmacy has good systems in place to effectively review the safe delivery of its services. The team uses the information and checklists to regularly assess the quality of services it provides. The pharmacy is good at investigating errors with dispensing. And it takes appropriate action to reduce the risks in the future.
		1.4	Good practice	The pharmacy is good at protecting people's private information. The pharmacy team uses its learning to keep people's private information secure.
		1.7	Good practice	The pharmacy advertises how people can provide feedback. And it acts on this feedback to try and improve services for people.
2. Staff	Standards met	2.1	Good practice	The pharmacy plans well for staff holidays and absence. And the pharmacy team members work flexibly to make sure the pharmacy has enough staff to provide its services. And they have the skills to support the delivery of the services provided.
		2.4	Good practice	The pharmacy team members work in an open and honest environment. They respond well when errors with dispensing happen. And they suggest changes to improve services. The pharmacy listens to feedback from people to inform changes to its services.
		2.5	Good practice	The pharmacy is good at listening when pharmacy team members have ideas. And it makes changes to support improved ways of working.
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	Standards	N/A	N/A	N/A

Principle	Principle finding	Exception standard reference	Notable practice	Why
and facilities	met			

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has systems in place to manage the risks associated with its services. And it effectively reviews the safe delivery of its services. It keeps the records it must by law. And it is good at protecting people's private information. The pharmacy advertises how people can provide feedback. And it acts on this feedback to try and improve services for people. The pharmacy responds well when mistakes happen. The pharmacy team members record and discuss mistakes to try and prevent something similar happening in the future. The team have the skills to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy premises included a dispensary set to one side of the pharmacy counter and a consultation room. There was a long bench running the full length of one side of the dispensary. The team separated the labelling, assembly and checking of prescriptions in defined areas of the bench. The pharmacist was seen supervising the pharmacy counter from where he stood.

The pharmacy had a set of electronically kept standard operating procedures (SOPs) for the services it provided. These included SOPs relating to Responsible Pharmacist (RP), near misses, dispensing incidents and high-risk medicines. The team said the SOP relating to controlled drugs (CDs) had recently been updated to include the dispensing of electronic CD prescriptions and the recent changes in CD schedule of gabapentin and pregabalin. And a dispenser correctly explained the changes. The SOPs checked had been written in July 2017, January 2019 and February 2019.

The pharmacy team recorded near misses on a near miss log displayed on the dispensary wall. The team completed a "first" check before the prescription was handed to the pharmacist to complete their check. So, all members of the dispensing team identified errors, including the pharmacist. And they discussed these individually and openly with the team member making the mistake. They completed a monthly patient safety report. And the pharmacist verbally discussed the learnings with the team. These discussions were not part of a formal meeting. The number of near misses recorded was relatively low. So, it may be more difficult to analyse the results for trends.

Examples of repeated errors included quantity and strength selection errors. A dispenser completing a "first" check during the inspection identified a near miss when metformin M/R tablets had been selected instead of the standard release. The two dispensers discussed the error and decided as the standard formulation was stored with the fast-moving lines the trainee dispenser had not realised there were two formulations. So, she used this learning to improve her knowledge. The near miss was recorded on the near miss log.

The pharmacy team recorded dispensing errors on the company's Pharmacy Dispensing Incident System (PDIS) and sent the information to the compliance team. If needed the pharmacist scanned evidence of e.g. the incorrect label or the box on to the report file. The store manager signed off the action plan. When actions from an incident included re-reading a SOP the team completed the action and made a record to evidence this. And the pharmacist signed this off as complete. An example viewed during the inspection showed an in-depth investigation had resulted in seven actions for the team to complete at

various stages of dispensing and supply. And it took into consideration several contributory factors. The team displayed a poster in the dispensary produced by head office. It contained learnings from an analysis of errors on prescriptions for children. Head office produced a pharmacy compliance communication. The pharmacy team had one dated May 2019 to read. The communication detailed learnings about a complaint from another branch. And information on lookalike sound alike medicines.

The team members were aware of their roles and responsibilities. They wore name badges with their name on. During the inspection there were several examples of team members working competently within their role, giving advice to people in the shop.

The pharmacy team completed a weekly compliance checklist form to audit compliance in a variety of areas, including data protection and patient safety procedures. It checked compliance with CD balance checks, fridge temperatures and date checking. The completion of the checks was shared with the compliance team in the store weekly.

The pharmacy displayed a notice detailing to people how to feedback about its services and how to raise concerns. And it had the information in a leaflet for people to pick up and take away. The team had received 96 per cent for an internal customer satisfaction survey January- February 2019. The pharmacist discussed how the results of a previous customer satisfaction survey had highlighted there could be an improvement in the way the team held private conversations. Since then he said that the team offered the use of the consultation room on a regular basis. The pharmacy had a complaints SOP.

The pharmacy had up to date indemnity insurance. The Responsible Pharmacist (RP) notice displayed the correct details of the RP on duty. And the entries in the RP record were complete. Of the sample checked, the electronic private prescription records contained full details of the private prescriptions dispensed. And emergency supplies records were completed detailing the reason for the emergency supply. The pharmacy completed the certificates of conformity for unlicensed medicines in line with MHRA requirements.

A sample of the entries in the CD register met legal requirements. The pharmacy team maintained running balances. And it checked the physical stock balance of CDs against the register entry once a week on Saturdays. The details of the checks were completed on a sheet kept in the front of the register, but not as a record in the CD register. If the sheet was lost there would be no evidence the stock balance check had been completed. During the inspection a check of the physical balance of Oxycontin 10mg tablet against the register balance was found to be correct. The pharmacy used a CD destruction register for patient returned medicines.

The pharmacy team members had completed training on data security and information governance (IG). And they had read and had access to General Data Protection Regulation (GDPR) guidance. They could give examples of how they used their knowledge to protect people's private information. For example, not giving out people's information but referring the request to the pharmacist. And a dispenser explained for telephone calls she would make sure she knew who she was speaking to before discussing people's medication. The pharmacy had a computer with patient medication records (PMR) available on the pharmacy counter. The details on the screen couldn't be seen by people waiting at the pharmacy counter. And the team switched off the screen when not in use. The prescription retrieval area was in the dispensary, so people's private information couldn't be seen by people at the pharmacy counter. This had recently been changed after an idea for change by the pharmacy team. The pharmacy used a shredder to destroy any confidential information. It was kept in the consultation room. There was no confidential information kept in there ready to be shredded.

The pharmacists had completed NVQ Level 2 safeguarding training. And the team had access to an in-

house SOP training module on safeguarding. One of the dispenser's training log was checked during the inspection. But, it was not possible to check all the team's completion of training as the pharmacist manager on duty didn't have access to a summary of all the team members training records. The team had completed dementia friends training. The pharmacy displayed a poster on the dispensary wall detailing local safeguarding contact details. The team couldn't give any examples of when they had used their knowledge to raise a concern about safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work flexibly to make sure the pharmacy has enough staff to provide its services. And they have the skills to support the delivery of the services provided. The pharmacy supports new members of staff through induction and training. And it provides team members with regular ongoing learning. So, they can keep their knowledge up-to-date. The pharmacy is good at listening when team members have ideas. And it makes changes to support improved ways of working.

Inspector's evidence

On duty at the time of the inspection the responsible pharmacist was one of the pharmacist managers. Also present was a part-time medicines counter assistant (MCA) and a part-time trainee dispenser. An NVQ Level 2 dispensing assistant started her shift part way through the inspection, allowing the MCA to have lunch. The pharmacist manager explained that the pharmacist always worked with a dispenser, so prescriptions could have the “first” check and then the pharmacist check completed.

Two further pharmacist managers, one full-time and one part-time worked in the pharmacy but weren’t present at the time of the inspection. One full-time and two part-time NVQ Level 2 dispensers also worked in the pharmacy and weren’t present for the inspection.

One of the dispensers had the responsibility to complete the staffing rotas three to four weeks in advance. The pharmacist manager authorised holidays. And this then automatically updated the rota. The rotas were printed out and displayed on the dispensary wall. The team also used a diary to record holiday requests. The team would discuss holiday and absence cover. And team members would put themselves forward for additional hours. They were happy to be flexible to ensure that the pharmacy had enough staff to provide its services. The team stated it was not difficult to cover when people were absent or on holiday. The pharmacists mostly worked split shifts, due to the long opening hours of the pharmacy. This allowed for a face to face handover which helped with communication and consistency of ways of working.

The pharmacist manager had been working in post since November 2018. As part of his training and induction he had attended the training academy. This involved a company induction for one day in Leeds. And then he completed further training over 12 weeks, both off-site training in Warrington and working in the pharmacy. The training included how the company worked, general store training and pharmacy training. After he had finished he had a meeting with the National Healthcare Manager, who completed checks and a competency sign off.

The pharmacy had training modules and SOPs held an electronic learning platform, for ongoing learning. The pharmacy proactively sent tasks to individual the team members to complete training. The training modules were role specific, but also related to business priorities such as promotions. Recent training included learning on the falsified medicines directive (FMD) and asthma and allergens. Training was also specific to the local store with two SOPs available for local services. There were questions attached to most training modules to confirm understanding. And sign off was required to say the training had been done.

Two of the members of staff working were relatively inexperienced or in-training. The pharmacist and

qualified dispenser were seen helping and supporting them in their roles. The trainee dispenser said she felt supported in her studies. And she felt at ease asking any questions she may have about her work. She said she had some time to complete her training during the working day, depending on the shift she was working. And she completed the rest at home.

The pharmacy team members were seen competently completing the tasks required of them. And they were seen exercising their professional judgement under the supervision of the pharmacist. One dispenser referred a person to the local walk-in centre. The pharmacist supervised the interaction but didn't feel the need to intervene. The team were also seen to refer OTC sales to the pharmacist appropriately. The pharmacist manager said he was given autonomy for professional decisions in the pharmacy. And he felt the store manager was supportive and understanding of his role. They worked well together. The pharmacist detailed several examples of when he had used his professional judgement to make decisions in the best interest of patients. Decisions made were documented on the patients PMR.

The pharmacist managers had regular appraisals. And there was system for the team to have one-to-one appraisals. But the team members working during the inspection couldn't remember having one.

Due to the long opening hours it was difficult to have regular full team meetings. The team completed handover discussions between shifts. And the pharmacy team had set up a Whats App group to share non-confidential information and learnings from near misses and errors.

The team said the pharmacy and store managers were open to ideas to improve ways of working or service delivery. The pharmacist detailed an idea that was in progress looking at completing blood pressure checks out in the supermarket. This hadn't been actioned yet. The team had suggested making changes to the layout of the dispensary. This had improved the pharmacist's supervision of the conversations at the pharmacy counter. The team felt comfortable raising concerns with any of the three pharmacist managers or the store manager. The pharmacy had a whistleblowing policy. The team members completed a company staff survey to provide feedback about the pharmacy and the wider company.

The pharmacy set targets for the pharmacist and team. And the pharmacist said he was supported to meet these targets. He said he felt the targets gave him an understanding of where the pharmacy was doing well and where he could focus more attention.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and well maintained. And it has arrangements for people to have conversations with the team in private.

Inspector's evidence

The pharmacy premises and the store in general were well maintained, clean and appropriate for healthcare services. There was enough bench space for the workload and services provided.

The pharmacy had a soundproofed consultation room of a suitable size to use for private conversations and the provision of services. It had a sink and a computer in the consultation room. The pharmacy had a sink in the dispensary for dispensing purposes, with hot and cold running water. And the team had use of the store toilets and staff areas.

The layout of the pharmacy counter and a gate into the pharmacy area prevented unauthorised entry during opening hours. The pharmacy was secured when closed. The heating and lighting were adequate. The appearance of the pharmacy reflected a professional healthcare provider.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to support people's health needs. And it has processes in place for the team to follow. The team members have the knowledge to support people taking high-risk medicines. And they provide advice and written information to help people take their medicines safely. The pharmacy sources, stores and manages its medicines appropriately.

Inspector's evidence

Access to the pharmacy was through the supermarket. There was adequate parking, including parking spaces for disabled people. And people in wheelchairs and with prams could access the pharmacy counter. The pharmacy was well signposted within the supermarket. The pharmacy had a sign for a hearing loop, but the team working during the inspection were unsure how it worked. The pharmacy displayed a range of leaflets and posters detailing the services the pharmacy offered and general healthcare advice. The practice information leaflet was available for people to pick up in the shop. And it detailed the services provided and the pharmacy opening hours. The pharmacy advertised as a healthy living pharmacy.

The pharmacy team used baskets during dispensing to keep people's prescriptions and medications together. And it also helped to prevent people's prescriptions from getting mixed up. The team used different sized baskets to indicate urgency. It kept small baskets by the pharmacy counter to use for prescriptions when people were waiting. The team printed the medication interaction labels and put them in the basket for the pharmacist's attention. It used a range of stickers during the dispensing process to highlight actions for the pharmacist or during the hand out process. These included CD stickers. The team signed the dispensed by and checked by boxes on the dispensing labels to provide an audit trail of the dispensing process and to take responsibility for their work. The dispenser completed a "first" check of the prescription before passing to the pharmacist for the clinical and final check. The pharmacy used clear bags for CDs.

The pharmacy dispensed medicines into multi-compartmental compliance packs for a few people. The member of the team working on a Monday ordered the prescriptions in enough time to allow a week to resolve any queries. When the pharmacy received the prescriptions the team member working on that day checked the prescriptions and dispensed the medicines into a pack, using the patient's record sheet. This was checked by the pharmacist and awaited collection by the patient, relative or carer. The pharmacy didn't offer a delivery service. The team members kept the patient record sheets up-to-date. And they made a record of any changes on the sheet and dated the change. Several of the record sheets looked untidy, with several medicines crossed through. This may increase the risk of an error happening. When the prescriber changed a person's medication the team member made the change on the record sheet, but they didn't record who they spoke to. So, it may be difficult to follow up in case of a query. The pharmacy supplied patient information leaflets (PILs) with the pack. And it annotated the pack with the identification markings, shape and colour of each medicine dispensed in the pack. There was an audit trail completed using dispensed by and checked by signatures on the pack of the members of the team involved.

The pharmacy team were aware of the requirements of the valproate pregnancy prevention programme (VPPP). And it had completed an audit to identify women to speak to. There was no-one

identified as part of the audit. The pharmacy had a poster up in the dispensary to highlight the requirements. And it kept some warning cards on the dispensing shelves with the stock. And it had stickers available to use. The pharmacist described the check he made with people taking high-risk medicines such as warfarin. He checked they had a recent blood tests and inquired to the results. But didn't make a record of the results. He attached a pharmacist advice sticker to the medication bag to ensure the pharmacist could speak to the patient when they came in to collect their medicines.

The pharmacists provided a range of services, both NHS and private. The pharmacist described how each of the pharmacists had completed training and had copies of certificates on-line of the patient group directions (PGD). The pharmacist couldn't access his at the time of the inspection. The pharmacy had SOPs available for the services provided.

All pharmacy (P) medicines were stored behind the pharmacy counter, which prevented self-selection. The pharmacy obtained stock from reputable wholesalers. The pharmacy used medicinal waste bins for out of date and patient returned medicines. These were stored appropriately in the dispensary. The pharmacy had denaturing kits available to destroy CDs.

The pharmacy had started preparing for the falsified medicines directive (FMD). It had the scanners and the software in place but was awaiting a password before being able to start. The pharmacy had provided training, but the team were unsure at which part of the dispensing process they would check the seals, verify and decommission.

The pharmacy had enough space and shelves to store its medicines and medical devices. The fridge and controlled drugs cabinet were of a suitable size. The team stored the medicines in an organised and tidy manner. The fridge temperature was in range on the date of the inspection, and for the sample of records checked. The pharmacy used stock control stickers in front of the products to help monitor stock levels.

The pharmacy had a SOP for date checking and a date checking rota in operation. The last checks had been completed on the day of the inspection. And the team had completed checks regularly through February, March and April in the current rota. The team member signed and dated the rota to confirm completion. The pharmacy used stickers to highlight short-dated stock. It kept a list of products expiring by month. And a team member checked the shelves monthly to remove the stock expiring the following month. The team annotated opening dates on liquid medication to ensure these were used before the expiry date.

The pharmacy received notice of safety alerts and drug recalls from head office and the Medicines and Healthcare products Regulatory Agency (MHRA). The team signed and dated a printed copy with the action taken. And it kept a record in a folder in case of queries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services provided. And it obtains its equipment from a reputable source.

Inspector's evidence

The pharmacy had hard copies of reference books available for the team to use, including the BNF and the BNF for children. And it had access to the internet. It had a suitable medical fridge in working order. And the pharmacy used a range of BR stamped measuring cylinders. The pharmacy had a CE marked blood pressure monitor. And the pharmacist explained this was replaced automatically by head office.

The computers were password protected. The pharmacy had a computer with access to the PMR on the pharmacy counter. The screen couldn't be seen by people waiting at the counter. And the team switched the screen off when its wasn't in use. The pharmacy positioned the computers in the dispensary in a way to prevent disclosure of people's private information.

The pharmacy team had individual NHS smart cards. But the smart card in the PMR during the inspection belonged to a dispenser who wasn't working. This was changed during the inspection.

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.