General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Handsworth Road, Handsworth, SHEFFIELD, S13 9BN

Pharmacy reference: 1109648

Type of pharmacy: Community

Date of inspection: 22/11/2019

Pharmacy context

This is a community pharmacy in an Asda supermarket in Handsworth, Sheffield. The pharmacy is open extended hours over seven days a week. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And the pharmacy offers services including seasonal flu vaccinations, the NHS new medicines service (NMS) and medicines use reviews (MURs). It also provides a substance misuse 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 the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow to help them deliver the services safely. It mostly keeps the records it must have by law. And it keeps people's private information secure. The team members discuss and record any mistakes that they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when, and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy was in the centre of the supermarket. The pharmacy was busy at the time of the inspection with several people leaving their prescriptions to be dispensed by the pharmacy team while they did their shopping in other areas of the supermarket.

The pharmacy had a set of standard operating procedures (SOPs). And they were held electronically. They included ones for responsible pharmacist (RP) regulations and dispensing. The superintendent pharmacist's team reviewed each SOP every two years. This ensured that they were up-to-date. The team members were required to complete a short quiz to assess their understanding after they had read an SOP. The pharmacy defined the roles of the pharmacy team members in each SOP. They described how they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy recorded near miss errors made while dispensing onto a paper near miss log. The errors were typically spotted by the pharmacist completing the final check. The team member who made the error was responsible for entering the details of the error into the log. The team members explained this helped them take ownership and responsibility for their errors and helped with their learning. The details recorded included the time and date of the error. But the team members did not always record the reason why an error might have happened. And so, they may have missed out on the opportunity to make specific changes to their practice to prevent similar errors happening again. The pharmacy completed an analysis of the errors that had been recorded each month. This was to identify any trends or patterns. And the findings were discussed with the team when most of the team members were working. Those team members who were not working, were informed of the findings when they next attended for work. The pharmacist explained he had noticed a series of selection errors with medicines that looked or sounded similar, known as LASA medicines. The team members discussed the errors and considered the steps they could take to prevent similar errors happening again. For example, they had recently attached red tape to shelf edges where the pharmacy stored several LASA medicines. This reminded them of the potential for mistakes with these medicines. They had also organised a rearrangement of a part of the dispensary which was prone to becoming untidy. The pharmacist explained he had noticed less errors involving medicines stored there since the rearrangement. The pharmacy recorded all dispensing errors which had reached the patient on an electronic reporting system called Pharmapod. And the details of each error were sent to the pharmacy's superintendent pharmacist's office. The pharmacy had recently supplied a person with the incorrect quantity of their medicines. To prevent a similar error happening again, the team members have made sure they always mark split packs clearly using a marker pen. Additionally, an alert note was put on the person's

electronic medication record to remind the team of the error and to take extra care.

The pharmacy had a complaints procedure. This was clearly advertised in its practice leaflet which was available at the medicine counter. A team member explained how she would deal with a potential concern. The pharmacy also advertised feedback through its annual patient survey. But the pharmacy did not display the results of the survey for people to see. The pharmacist explained how extra seating had been provided in the waiting area following feedback through the questionnaire.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of Sevredol 10mg tablets matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines, but several were not completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. And they were seen offering the use of the consultation room to people to discuss their health in private. They had all undertaken general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only the team members could access. There was a privacy notice on display in the retail area. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The pharmacy had procedures in place to help the team members safeguard the welfare of vulnerable adults and children. And four team members had completed training via the Centre for Pharmacy Postgraduate Education. The pharmacy provided the team with written guidance on managing and reporting a potential safeguarding concern. But the team members were unable to locate it. The team members explained they would always report a potential concern to the pharmacist on duty and would escalate the concern to the pharmacy’s superintendent pharmacist’s office if they felt the need to do so.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy team members complete training to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection one of the pharmacy's two regular pharmacists was on duty. A part-time pharmacy assistant and a part-time trainee pharmacy assistant supported him during the inspection. The pharmacy also employed a second pharmacist and four other part-time pharmacy assistants. At least one dispenser always supported the pharmacist. The pharmacist hours were split between the pharmacist on duty and the second pharmacist. But they worked together for around 6 hours every week. This allowed them to complete various other tasks such as basic administration, and to provide services such as flu vaccinations. The pharmacy organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. The pharmacy could use 'pharmacy busters' if they felt they need additional support. The 'pharmacy busters' were people who normally worked in other areas of the supermarket, for example, on the checkouts. But they had completed some training to allow them to carry out basic tasks in the pharmacy, for example, taking in prescriptions and handing out dispensed medicines. The team members did not take time off in the run up to Christmas or Easter, as these were the pharmacy's busiest times of the year.

The team members were able to access the online training system, called Helo, to help them keep their knowledge and skills up to date. They received training modules to complete periodically. Many of the modules were mandatory to complete. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not always receive set time during the day to allow them to complete the modules. And so, they completed some training in their own time. They were in the process of completing training based on an over-the-counter medicine for migraines.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacists or the pharmacy's regional manager, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The team members felt the targets did not impact their ability to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, tidy and professional in appearance. There was signage outside of the supermarket which indicated there was a pharmacy inside the building. The dispensary was small, but the team was managing the space well. It was generally tidy and well organised during the inspections. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which was shared with the supermarket. It had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. There was a good-sized, soundproofed consultation room at the side of the retail area. The room was smart and professional in appearance and was signposted by a sign on the door. It was kept locked when it was not in use to prevent the risk of any unauthorised access. It contained two seats and had a sink. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The team members take steps to identify people taking high-risk medicines. And, they provide these people with advice and information to help them take these medicines safely. The pharmacy manages the risks associated with the dispensing process well. It sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the supermarket car park to an automatic entrance door. And so, people with prams and wheelchairs could enter the pharmacy unaided. There were several disabled and parent and child parking spaces. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours around the retail counter. It had a small healthy living zone close to the seating area in the retail space. And there were several healthcare related leaflets available for people to select and take away with them. For example, for smoking cessation and breast health. There was a notice on the wall in the retail area outlining how people should safely return unwanted medicines to the pharmacy. And there was a notice listing the details of several other pharmacies in the local area. The team explained that people could refer to the notice if they pharmacy was closed, and they needed to use a pharmacy that was open.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight if a person was eligible for a flu vaccination. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines. This helped the team stop people’s prescriptions from getting mixed up. The baskets were of different colours. This helped the team differentiate between prescriptions that were urgent and those for people who were calling back to the pharmacy later. The team used a long bench to dispense prescriptions and the pharmacist used the end of the bench to complete final checks which was out of sight of the retail area. This allowed him to complete the checks without being distracted or interrupted.

The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people’s medication bags to remind them that the bag contained a high-risk medicine. When the person presented at the pharmacy to collect their medicines, the pharmacist asked them a series of questions to ensure they were taking their medicines safely. For example, if a person was supplied with methotrexate, the person was reminded that they dose was usually to taken weekly. If they were supplied with warfarin, the pharmacist explained he would remind the person of the importance of having regular blood tests and reporting any signs of bruising or excessive bleeding. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical

situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. Two people were identified. The pharmacist provided the people with appropriate advice about the programme. The pharmacy kept dispensed CDs and medicines stored in the fridge, in clear bags. This allowed the team and the person collected the medicine, to complete a final visual check of the medicine to ensure it was accurate.

Pharmacy (P) medicines were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every twelve weeks, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next six months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The pharmacy had the correct scanners and software installed to help the team members comply with the requirements of the falsified medicines directive (FMD). And the team members had received training on how the follow the directive. They explained they were scanning and undertaking manual checks of tamper evident seals on packs for some, but not all of the pharmacy's medicines. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people 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.