

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, St. Lawrence Way, Darlaston,
WEDNESBURY, West Midlands, WS10 8UZ

Pharmacy reference: 1112309

Type of pharmacy: Community

Date of inspection: 12/03/2024

Pharmacy context

This is a community pharmacy located within a large Asda supermarket in Darlaston, West Midlands. The pharmacy is open extended hours over seven days. The pharmacy dispenses both NHS and private prescriptions and sells a range of over-the-counter (OTC) medicines. And it provides NHS funded services such as Pharmacy First service, blood pressure testing and seasonal vaccinations. The pharmacy team dispenses medicines into multi-compartment compliance packs for some people to help make sure they remember to take them.

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	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 adequately manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team can access written procedures to make sure they work safely, and they complete tasks in the right way. They discuss their mistakes so that they can learn from them. And team members understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

The RP was a locum pharmacist and had not worked at this pharmacy before. She had read the Asda locum pharmacist onboarding guide and SOPs to accept the booking. The pharmacy had two pharmacist managers who were not present for the inspection, and they were relatively new to the team. There were various documents and records that the dispensing assistants could not locate during the inspection, such as the near miss reviews or patient safety reports to demonstrate that these reviews were done regularly. Some records were several years old, and the team were uncertain where the pharmacist managers recorded or stored the latest ones.

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were issued by head office and uploaded to the team member's individual electronic learning (eLearning) account. This was a new process and the team members that were on duty during for the inspection had not yet had the opportunity to undertake training on the SOPs held within their accounts. They were unsure how to access their eLearning accounts on the pharmacy computers and used their mobile phones instead. The team did not appear confident in how to use the new eLearning platform and could benefit from additional training and experience in using it.

A near miss log was available and near misses were recorded sporadically, suggesting that they were not always recorded. Near misses were discussed with the dispenser involved to help make sure they learnt from the mistake, and any learning was shared with the team. The team demonstrated examples of medicines that had been highlighted to reduce the risk of them being selected in error during the dispensing process. LASA (look alike, sound alike) medicines were also clearly labelled. A dispensing assistant explained how she would handle a dispensing error and they would gather as much information as possible from the person. The pharmacist manager would then investigate and report the error when they were next on duty.

Members of the pharmacy team were knowledgeable about their own roles and discussed these during the inspection. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how she managed requests for codeine containing medicines. Pharmacy staff were wearing uniforms and name badges to identify themselves as pharmacy team members.

A complaints procedure was in place. A dispensing assistant explained the process for handling a complaint or concern. She said that she would speak to the person first and would try to resolve the issue, and would refer to the pharmacist manager, department manager, customer services desk or provide contact details for head office if the complaint was unresolved. A customer leaflet was available

which explained the complaints process. People had complained to customer service when the pharmacy team had used their professional judgement and refused a sale when they thought it was inappropriate, for example, codeine containing medication. The team said that a department manager would usually ask the pharmacist about their decision so that they could explain it to the customer, but they did not put any pressure on the pharmacist to reconsider.

The pharmacy had professional indemnity insurance arrangements in place. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log complied with requirements. Controlled drug (CD) registers were in order and a random balance check matched the balances recorded in the register. A patient returned CD register was in place. Private prescriptions were recorded electronically, and records were in order. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and destroyed securely at head office. The pharmacy team members had their own NHS smartcards and they confirmed that passcodes were not shared. The ASDA smartphone app that contained the SOPs had been updated to increase security, but the team were experiencing issues with the two-stage authentication. The pharmacy team had completed training on safeguarding and data protection as part of their mandatory annual compliance training. The pharmacy team understood what safeguarding meant and a list of safeguarding contacts was displayed in the dispensary. The dispensing assistants gave examples of types of concerns that they may come across and correctly described what action they would take.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so they always have enough cover to provide the services. They work well together in a supportive environment and can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of two pharmacist managers, two dispensing assistants and five trainee dispensing assistants. Home deliveries were carried out by a third-party courier company. Holidays were provisionally booked with the pharmacist managers and submitted electronically for final approval. Cover was provided by other staff members as required and the pharmacist manager prepared staffing rotas approximately a month in advance so that cover could be arranged. The pharmacy had an extended hours NHS contract and locum pharmacists worked when the pharmacist managers were off.

Pharmacy team members completed ongoing training provided by ASDA which aligned to the launch of new services, NHS Pharmacy Quality Scheme (PQS), annual compliance training and pharmacy updates. Several members of the pharmacy team were working towards an accredited dispensing assistant qualification and were provided with training time. But this was not planned into their working week or protected so it was unclear how often they had time to complete their course. Due to the extended opening hours and different shift patterns, written communication and small group briefings helped make sure that all members of staff were updated on topics such as pharmacy business, company updates, ongoing stock issues and daily tasks.

The pharmacy team worked well together during the inspection and team members were observed helping each other with tasks. Team members said that they could raise concerns or suggestions with the pharmacist manager or the department manager and felt they were responsive to feedback. The RP was observed making herself available to discuss queries with people and giving advice when she handed out prescriptions. The locum pharmacist did not have any formal targets set. She said there was a reasonable expectation that she would offer professional services, such as the NHS Pharmacy First service and the NHS hypertension case-finding service, if a suitable patient was identified.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy team uses a consultation room for services and if people want to have a conversation in private.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the maintenance department in store. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were securely stored behind the medicines counter. A secure area of the stockroom was available for the pharmacy team to use as additional storage space.

The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and accuracy checking activities took place on separate areas of the worktops. There was a private soundproof consultation room which was used by the pharmacist. The consultation room was professional in appearance and door to the consultation room remained locked when not in use. The dispensary was clean and tidy and was cleaned by pharmacy staff and an in-store cleaner. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap were available. The store had an air-cooling system which regulated the temperature. Lighting was adequate for the services provided.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers and stores them securely. People receive appropriate advice about their medicines when collecting their prescriptions.

Inspector's evidence

The pharmacy had step-free access from a large car park. The pharmacy opened for longer hours than many other pharmacies in the area, including late nights, and Saturday and Sunday. The range of services provided was displayed and pharmacy leaflets explaining each of the services were available for customers. The pharmacy staff used local knowledge and the internet to refer patients to other providers for services the pharmacy did not offer. The pharmacy had a hearing loop available.

The pharmacy offered the NHS Pharmacy First service. The team had undergone training, they had quick reference guides, the NHS PGDs (patient group directions) and supporting documentation available for reference. The NHS system that the pharmacy team used had been upgraded and the pharmacy team had been unable to access the system to check whether people had been referred from NHS 111 since. They had reported this as an IT issue and sourced electronic copies of the information usually held within the system so that they had this for reference for people presenting at the pharmacy for the service.

Medicines and medical devices were dispensed into baskets to ensure prescriptions were not mixed up together. Different coloured baskets were used to prioritise prescriptions. Team members signed the 'dispensed-by' and 'checked-by' boxes on medicine labels, so there was a dispensing audit trail. The team were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. The team dispensed valproate containing medicines in original packaging and provided the associated counselling materials.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. The date checking records could not be located but the team confirmed that the dispensary was date checked regularly. Medicines were obtained from a range of licenced wholesalers and generally stored in an organised manner on the dispensary shelves. There was a lack of shelf dividers in some sections of the pull-out storage drawers had led to different strengths of the same medicines becoming mixed together. This could increase the chance of selecting the wrong strength in error and the team agreed to either order more from head office or use plain dispensing boxes to divide medicines. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. Drug alerts and drug emails were sent as an alert from head office.

The controlled drug cabinet was secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. The CD keys were in the possession of a pharmacist and secure procedures for storing the key overnight were in place. Fridge temperature records were maintained, and records showed that the pharmacy fridge was not always working within

the required temperature range of 2°C and 8°C. There were some instances where the minimum fridge temperature was recorded as below 0°C and it did not appear that any action had been taken to investigate this. However, the RP had checked the fridge temperature that morning and found it to be within the required range. The RP and dispensing assistant agreed to contact ASDA House to get further guidance on what action to take.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

Equipment for clinical consultations had been procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available. Computer screens were not visible to members of the public. Cordless telephones were in use, and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.