

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Old Park Lane, OLDBURY, West Midlands, B69 4PU

Pharmacy reference: 1115507

Type of pharmacy: Community

Date of inspection: 15/04/2024

Pharmacy context

This is a community pharmacy located within a large Asda supermarket in Oldbury, 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 the Pharmacy First service and blood pressure testing.

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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow 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 the team members understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the 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 that has been implemented and some team had not yet had the opportunity to undertake training on all of the SOPs that were available to them.

A near miss log was available and near misses were recorded. Near misses were discussed with the dispenser involved to ensure they learnt from the mistake. One of the pharmacist managers reviewed the near miss log at the end of the week and identified if there were any patterns or trends that could be used learning opportunities. The logs were also reviewed at the end of the month and a patient safety action plan was created. The outcome of the weekly and monthly reviews was discussed with the pharmacy team members. The team gave some examples of medicines that had been separated to reduce the risk of them being selected in error during the dispensing process. The pharmacist manager had a clear understanding of the process for reporting and investigating a pharmacy incident.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how he managed requests for codeine containing medicines.

A complaints procedure was in place. The pharmacist manager 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 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 occasionally complained to the in-store customer service team when a member of the pharmacy team had used their professional judgement and refused a sale of a medicine 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 two random balance checks 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 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 three pharmacist managers, five dispensing assistants and a trainee dispensing assistants. Holiday requests were submitted electronically and approved by the department manager. Cover was provided by other staff members as required and the pharmacist managers 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. Due to the extended opening hours and different shift patterns, written communication, small group briefings and one-to-ones helped make sure that all members of staff were updated on topics such pharmacy business, company updates, ongoing stock issues and daily tasks. The pharmacy team were observed working well together, and they helped each other with tasks. Team members said that they could raise concerns or suggestions with the pharmacist managers 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.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team members in private when needed.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the internal maintenance department. 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 signposted to people using the pharmacy. The consultation room was professional in appearance.

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. Members of the team used local knowledge and the internet to refer people to other providers for services the pharmacy did not offer. The pharmacy had a hearing loop available.

The team were pro-actively making people using the pharmacy aware that it was scheduled for closure in July 2024. They were telling people where other local pharmacies were and that they would need to change their nominated pharmacy before July so that they could continue receiving their medicines without interruption.

The pharmacy offered the NHS Pharmacy First service. Posters were displayed advertising the service to people using the pharmacy. The team had undergone training and had read the company SOPs. They had quick reference guides available and the NHS PGDs (patient group directions) and supporting documentation had been printed for reference.

Medicines were dispensed into baskets to ensure they 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 for prescriptions. The team were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. People were sent text messages when their prescriptions were ready to collect. The team explained that this was a useful tool which helped to reduce the number of telephone calls to the pharmacy as people knew they would get a text.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically.

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. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of

2° and 8° Celsius.

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 suitably 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.