General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, ASDA Superstore, Radford Road, Hyson Green, NOTTINGHAM, Nottinghamshire, NG7 5FP

Pharmacy reference: 1035714

Type of pharmacy: Community

Date of inspection: 04/03/2024

Pharmacy context

This community pharmacy is towards the front of a busy supermarket which is in a suburb of Nottingham. The pharmacy is open from seven days a week. Its main activity is dispensing NHS prescriptions and providing advice over the counter. It also offers services under the NHS Pharmacy First scheme; flu, meningitis, and pneumococcal vaccinations; the hypertension case-finding service; and substance misuse treatment.

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's team members follow written procedures to provide services safely. They try to use mistakes that happen as opportunities to learn. But these events aren't always recorded which may lessen the ability of the pharmacy to identify any patterns or trends and make improvements. The team members know what they can and cannot do when there is no pharmacist present. They protect people's personal information and the pharmacy keeps the records it needs to be law. The team knows what to do to protect vulnerable people.

Inspector's evidence

The pharmacy's services were supported by written standard operating procedures (SOPs) and these were reviewed regularly. New team members were expected to read SOPs relevant to their roles when they started, and all team members had to read updated SOPs as they were issued. Progress against this activity was tracked. There was evidence of team members following dispensing SOPs. For example, prescription labels were initialled at the dispensing and checking stages.

The company provided internal checklists to support the completion of routine governance tasks. These checklists were not always annotated as intended but one of the resident pharmacists explained the team was very familiar with the checks required and they were done routinely.

Team members explained how they would be made aware of any mistakes they made during the dispensing process by the pharmacist. Learnings from mistakes were shared with the rest of the team. Dispensing mistakes corrected before they were handed out (near misses) were sometimes recorded on a paper form though one of the pharmacists accepted this didn't always happen. Dispensing mistakes which had not been detected before being handed out (errors) were recorded in more detail and were reviewed in much more detail to prevent similar events happening in future. Details of these were also reported electronically to the pharmacy superintendent (SI). The team said that previous mistakes had led to a greater focus on making sure the correct form of a medicine was selected. And some medicines with similar names or similar packaging had been highlighted to the team to urge greater care when choosing the right item. There had also been a focus on making sure medicines were handed out to the right people. There was a company complaints procedure which the pharmacist was able to describe. Information about how people could provide feedback about the service they had received was available.

When asked, team members could explain what they could and couldn't do in the absence of a responsible pharmacist (RP). They could describe the types of questions they would ask when selling medicines and knew when to refer to the pharmacist for help. Team members knew about the recent reclassification of codeine linctus.

The pharmacy's services were appropriately insured so people receiving services would be protected. The RP notice on display accurately reflected the RP on duty. The RP record and records about controlled drugs (CDs) were complete and running balances were checked regularly. For those spot-checked during the visit, the physical stock in the cabinet agreed with the recorded balance. Patient-returned CDs were recorded in a designated book and were disposed of promptly. Private prescription records were made electronically. A small sample of these was checked and the prescriber details had

not always been recorded accurately. The pharmacist said they would make the team aware of this and remind them to record the correct information. Unlicensed medicines were supplied rarely. One record checked did not include details of the person supplied the medicine. This was also pointed out to the pharmacist.

The pharmacy protected sensitive information in several ways. Team members used their own NHS smartcards to access electronic prescriptions and didn't share passwords for these. Confidential waste was separated and disposed of securely. And there was mandatory training about information governance, supported by written procedures. Information on prescriptions waiting to be collected was not visible to the public.

There were written procedures to help make sure the pharmacy could protect vulnerable people appropriately. Staff, including the resident pharmacists, had completed safeguarding training relevant to their roles. The team was able to describe the types of situations which might need referring to other agencies for support and advice. There were close working relationships with the local substance misuse team. The pharmacist explained how concerns about people receiving treatment through this service would be reported, including missed doses, so people were safeguarded.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who have the right skills or who are doing the right training to provide the pharmacy's services safely. They are supported in ongoing learning and development, and they can have time at work to complete training. The team uses mistakes as opportunities to learn and improve.

Inspector's evidence

The team had been through a significant amount of change with a few experienced members of staff leaving within a short period of time. At the time of the inspection the two employed resident pharmacists were on duty. The rest of the team comprised: three qualified dispensers, and three trainee medicine counter. The pharmacy was also trying to recruit for a further dispenser. The team commented that the level of trade was quieter than normal during the visit, but the team coped well with their workload and were observed worked closely together, referring queries to the pharmacist where needed.

There were some certificates displayed showing accredited training completed by team members, though it appeared some of these belonged to people who no longer worked at the pharmacy. New starters were enrolled on suitable training courses relevant to the roles they undertook. The team members were provided with other training materials from their head office to help keep their skills and knowledge up to date. Some of the training was considered mandatory to complete and progress against this was monitored. When asked, team members said they would get time at work to complete training if needed. The pharmacists had completed the necessary training to provide the Pharmacy First services and other staff members were progressing through tailored training to support these services.

Information was shared amongst the team in a variety of ways including through team meetings (usually on a Monday), group chats through an app, and briefing materials. The weekly meetings included discussions about any dispensing mistakes to share learnings. Team members said they could share suggestions about how to improve the way the pharmacy worked. And the team members asked said they could discuss concerns with the resident pharmacists. The pharmacists said they felt able to exercise their professional judgement when delivering services and explained that their decisions were supported by in-store management.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are suitable for the services the pharmacy provides and they are clean and well-organised. People can have a conversation with a member of staff in private, in the consultation room.

Inspector's evidence

The pharmacy was very visible to people coming into the store. The entry doors opened automatically meaning it was readily accessible to people with wheelchairs, prams or other mobility problems. Access to the dispensary was restricted and activities carried out in the dispensary were largely out of view of the public, meaning staff were less likely to be disturbed mid-task. But it was still possible for the pharmacists to supervise activities taking place on the front counter.

Dispensary benches were clear of clutter and various sections of bench and shelving were used for designated purposes, to reduce risks. Pharmacy-only and prescription medicines were kept out of the reach of the public. Heating and lighting were suitable throughout. And all areas of the premises were clean. Staff had access to hygiene facilities including separate hand-washing arrangements. The sink in the dispensary had hot and cold running water. The premises could be secured to prevent unauthorised access.

A small consultation room was located just off the shop floor, and this was used for services and private conversations. It was well-screened and had enough space for the activities undertaken. The room had access to patient medication records, lockable storage for sundries and equipment, and seating. There was no confidential information left on display in the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. It dispenses prescriptions in an organised way. Its team members take extra care with higher-risk medicines so people get suitable advice. And the pharmacy gets its stock from reputable sources and stores it safely. It also has good systems in place to make sure the medicines it supplies are fit for purpose.

Inspector's evidence

Information about the services the pharmacy offered, including Pharmacy First, were advertised by way of leaflets and posters displayed at the pharmacy. Access to the pharmacy was possible for people who used wheelchairs or those with prams and there was ample onsite parking. The pharmacy was open for seven days a week and team members commented that uptake of services such as Pharmacy First tended to increase at weekends or when other service providers were closed.

Dispensing was observed being undertaken in an orderly way during the visit and there was clear separation of dispensing and accuracy checking activities. Baskets were used to prevent prescriptions for different people getting mixed up. And there was an audit trail on all dispensed items showing who had undertaken various tasks during the process. Some prescriptions for higher-risk medicines were highlighted so people could receive additional information when the medicines were handed out. When asked, the pharmacist was able to clearly explain the information that needed to be provided about pregnancy prevention when supplying sodium valproate. And they knew how to attach dispensing labels to the manufacturer's packs so as not to obscure important information. They also knew about the recent changes that meant valproate-containing medicines were to be supplied in their original packs. Instalment prescriptions for substance misuse treatment were annotated correctly when doses were supplied or weren't collected so pharmacists would know if follow-up action was needed.

The pharmacy team members had access to dedicated SOPs and patient group directions (PGDs) for the Pharmacy First service. When checked, some of the PGDs had not been signed by the resident pharmacists but this was rectified straight after the visit.

The pharmacy got its medicines from licensed wholesalers and unlicensed 'specials' were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicine stock for dispensing was stored in an orderly fashion in the dispensary. Pharmacy-only medicines were stored out of reach of the public. The pharmacy checked the expiry dates of its stock regularly and kept a record about these checks. Short-dated items were identified to alert staff and reduce the risk of supplying when no longer in date. And there was a process to remove these from dispensing stock at a suitable time. When a sample of medicines was checked at random, there were no date-expired medicines found. Medicines were kept in appropriately labelled containers. Out-of-date medicines and patient-returned medicines were transferred to designated bins. These were stored away from other medicine stock and were disposed of through licensed waste contractors. There were processes followed to denature CDs before disposal. Appropriate arrangements were in place for storing CDs and access to the CD cabinet was well-controlled.

There was ample storage capacity for medicines requiring cold storage. Temperature ranges for the

pharmacy fridge were checked regularly to make sure they remained suitable for storing temperature-sensitive medicines. The records seen were within the appropriate range of between 2 and 8 degrees Celsius. The pharmacy was informed about drug recalls and safety alerts through company communications and there was a robust process in place to make sure the pharmacy responded to these promptly. An audit trail of this activity was kept. Following a patient level recall, people who had been supplied Nutramigen had been contacted to check if they had any of the affected batches and to arrange return if needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure its equipment is safe to use.

Inspector's evidence

The pharmacy had measuring and counting equipment of a suitable standard to use when dispensing and providing other services. The medicine measures seen were clean. There was suitable equipment for disposing of sharps waste and medicines waste and this was stored safely. Equipment was available to support the Pharmacy First service including disposable ear funnels of different sizes for the otoscope. Electrical equipment appeared to be in good working order and portable appliances were safety tested regularly.

The pharmacists had access to up-to-date reference sources, largely electronic, to support advice and clinical checks. Patient medication records were stored electronically and access to these was password protected. NHS smartcards to access summary care records and electronic prescriptions were not shared. Screens containing sensitive information were not visible to the public.

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.