

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Wesley Road, NOTTINGHAM,
Nottinghamshire, NG16 4ED

Pharmacy reference: 1105689

Type of pharmacy: Community

Date of inspection: 02/07/2024

Pharmacy context

This pharmacy is located at the rear of an Asda store. Most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. And it provides a seasonal flu vaccination service and some other NHS funded services including the Pharmacy First Service. The pharmacy operates over extended hours and stays open late in the evenings.

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 generally manages risks to make sure its services are safe. It keeps its records up to date, so it can show it is providing services safely. Pharmacy team members record their mistakes so that they can learn from them, and they act to help stop the same sort of mistakes from happening again. The team has written procedures on keeping people's private information safe and understand how it can help to protect the welfare of vulnerable people.

Inspector's evidence

There were up to date electronic Standard Operating Procedures (SOPs) for the services provided. Pharmacy colleagues were required to read SOPs appropriate to their roles. Records of this were maintained on an online learning platform. Roles and responsibilities of staff were set out in SOPs. The responsible pharmacist (RP), who had worked as the resident pharmacist at the pharmacy for five months, said he hadn't read all of the SOPs yet, so there was a risk that he might not fully understand the pharmacy's procedures. He confirmed that he would read the outstanding SOPs as a priority. A dispenser could clearly describe her duties which were in line with her role. The staff were wearing uniforms and name badges showing their role. The incorrect name of the RP was on display. The RP displayed his notice when this was pointed out and said it had been an oversight and he had forgotten to change the notice that morning.

Dispensing incidents were reported electronically which could be viewed by the compliance team at head office. Learning points were included. For example, following an incident when the incorrect strength of sertraline was dispensed, the pharmacy team had tidied up and decluttered the dispensary shelves and drawers, and better separated look-alike and sound-alike drugs (LASAs). Near misses were reported electronically and the RP confirmed they were reviewed, and any learning points were discussed with the pharmacy team. A member of the team pointed out that they had separated the LASAs amlodipine and amitriptyline after near miss errors. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out.

There was an SOP for dealing with complaints. There was a patient information notice which showed the complaint procedure and gave the details of who to complain to. But it could not be clearly seen from the retail area, so people visiting the pharmacy might not know how to raise a concern or leave feedback. The RP said he would move the notice to a more prominent position and confirmed he had done this following the inspection.

Professional indemnity insurance arrangements were in place. Private prescription and emergency supply records, and the controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Adjustments to methadone balances were attributed to manufacturer's overage without a written assessment of whether the adjustment was within a reasonable range or should be investigated and reported to the accountable officer. The RP confirmed that if the discrepancy was higher than usual, he would calculate the discrepancy as a percentage, and he knew what percentage should be reported. Patient returned CDs were recorded and disposed of appropriately. The RP

record was generally in order, but the RP had entered the time he expected to cease his duties in the RP record on the morning of the inspection. This risked the accuracy of the record if there were any changes.

Members of the pharmacy team had read and signed the information governance (IG) SOP which included patient confidentiality. Confidential waste was collected in designated bags which were collected by a waste disposal company. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions and paperwork containing patient confidential information were generally stored appropriately so that people's details could not be seen by members of the public.

A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The RP had completed level two training on safeguarding. Royal Pharmaceutical Society (RPS) guidance on safeguarding was on display and the contact numbers of who to report concerns to in the local area. The pharmacy had a chaperone policy. This was highlighted to people on the patient information notice. Some team members had completed training on the 'Safe Space' initiative, where pharmacies were providing a safe space for victims of domestic abuse.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members complete the essential training they need to do their jobs and they are comfortable providing feedback to the regular pharmacist. But ongoing training does not happen regularly, so the team's knowledge may not always be fully up to date.

Inspector's evidence

The RP and two qualified dispensers (NVQ2 or equivalent) were on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team members were observed working collaboratively with each other and people who visited the pharmacy. There was another qualified dispenser and four trainee dispensers on the pharmacy team, and the pharmacy was currently recruiting for an additional dispenser. Absences were covered by re-arranging the staff rota. In an emergency, colleagues could be transferred from other departments in the store, but as they weren't generally healthcare trained, the duties which they could carry out were very limited. There was the option of transferring pharmacy team members from a neighbouring branch. The team liaised with the area manager when this was required. The RP had locum pharmacist cover two afternoons a week which he said he used to complete any management duties.

Members of the pharmacy team carrying out the services had completed appropriate training. The RP felt competent at providing the NHS Pharmacy First service and said he had received training on ear examination and the use of an otoscope. Team members had access to an online training platform and there were individual dashboards where completed training and assessments were recorded. The RP and area manager could view and monitor this. Team members did not get protected training time, and usually had to complete training in their own time. Team members couldn't recall any recent training, other than reading SOPs, and some team members had outstanding SOPs to read. Team member's performance and development wasn't routinely discussed. There was no formal appraisal process for colleagues apart from pharmacists.

Informal team meetings were held when there were issues to discuss. The RP used an electronic messaging App to communicate with team members who hadn't been at the meeting. A dispenser confirmed there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the RP about any concerns she might have and was comfortable admitting errors and discussing errors.

The RP felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said targets were set for the NHS New Medicine Service (NMS), Pharmacy First Service and hypertension case finder service. He said these were challenging, but he didn't allow targets to compromise patient safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room so people can have confidential conversations with team members if needed.

Inspector's evidence

The pharmacy premises were reasonably clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with one chair. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office. The pharmacy team used the store's facilities which included a staff tearoom and WCs with wash hand basins and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sink. Hand sanitizer gel was available. The consultation room was equipped with a sink, and was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services such as the pharmacy first service and when customers needed a private area to talk.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. The pharmacy gets its medicines from licensed suppliers, and it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to everyone, including people with mobility difficulties and wheelchair users. There was an automatic door at the store's entrance. There was a hearing loop in the consultation room. A list of the services provided by the pharmacy was on display along with the opening hours. There was a small range of healthcare leaflets for people to read or take away. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. For example, travel vaccinations.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. The dispensary shelves and drawers were reasonably well organised but untidy in places which increased the risk of picking errors. The RP explained that the team were in the process of tidying up the dispensary shelves and drawers. Some of the dispensary drawers were broken and one drawer which was full of stock was on the floor. This was a tripping hazard and compromised the integrity of the medicines in it. A dispenser confirmed that the faulty drawers had been reported many times, but no action had been taken. The RP confirmed that he would chase this up. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Alert' stickers were used to highlight high-risk medicines such as warfarin for extra checks and counselling. The team were aware of the requirements for a Pregnancy Prevention Programme to be in place and original packs were dispensed when people were prescribed valproate.

A dispenser explained what questions she asked when making a medicine sale and she knew when to refer the person to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be misusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the floor. The keys were under the control of the RP during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. Shutters were pulled down over this area and locked when the pharmacy was closed.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Dates had been added to

opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via email messages from head office and from the NHS's Central Alerting System (CAS) area team. These were read and acted on by a member of the pharmacy team. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. For example, the electronic British National Formulary (BNF) and the Electronic Medicines Compendium (eMC) websites. There was a clean medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. A sharps bin and other equipment required for the flu vaccination service was available in the consultation room. The pharmacy had suitable blood pressure testing equipment. An otoscope was available for use in the Pharmacy First service. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. A cordless phone was available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.