General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asda Pharmacy, Lombard Street, NEWARK, Nottinghamshire, NG24 1XG

Pharmacy reference: 1110269

Type of pharmacy: Community

Date of inspection: 11/04/2024

Pharmacy context

The pharmacy is in a supermarket, in the market town of Newark-on Trent in Nottinghamshire. It is open seven days a week. The pharmacy's main services are dispensing prescriptions and selling over-the-counter medicines. It provides a range of NHS advanced services including the New Medicine Service, Hypertension Case-Finding Service, and the NHS England Pharmacy First Service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not always make adequate records when people receive the wrong medicine. Pharmacy team members do not demonstrate appropriate learning following the mistakes they make during the dispensing process. And pharmacists do not act in a timely manner to follow the correct reporting processes when they find a discrepancy in the controlled drug register
2. Staff	Standards not all met	2.2	Standard not met	Pharmacy team members are not enrolled on appropriate learning courses relevant to the scope of activities they carry out.
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 not all met**

Summary findings

The pharmacy does not adequately act to manage the risks it identifies. It does not always act to report and learn from mistakes or act on discrepancies discovered during routine balance checks of controlled drugs. And its team members do not engage in regular learning to help reduce the risk of a similar mistake occurring. The pharmacy keeps people's information securely and it mostly keeps the records required by law. It advertises how people can provide feedback about its services. And its team members have the knowledge and resources to support them in identifying and reporting safeguarding concerns.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The superintendent pharmacist's team reviewed these on a rolling cycle. And it introduced SOPs to support the implementation of new services in a timely manner. Team members reported completing learning for the SOPs. But they could not access the SOPs from the pharmacy's computers due to an IT error. A team member was able to demonstrate their learning record from another computer in the store with the support of a customer service manager. A discussion highlighted the risks of not having SOPs readily available for team members to refer to within the pharmacy. The pharmacy relied on locum pharmacists providing cover, the responsible pharmacist (RP) during the inspection had last worked at the pharmacy around a year ago. They were familiar with the company's processes, and they made themselves available to support team members. For example, serving on the medicine counter and responding to queries professionally. A team member explained what tasks they would not complete if the RP took absence from the pharmacy. The pharmacy had a diary containing checklists of daily and weekly tasks requiring completion. But its team members did not always complete the diary daily to support it in monitoring the completion of these key tasks. The two completed entries for the month of April 2024 within the diary contained supportive handover notes to team members.

The pharmacy had processes for recording and learning from adverse safety events. But team members did not always follow these. A team member explained that pharmacists would record the mistakes they identified during the dispensing process, known as near misses. But the last completed near miss records available were from August 2023. The current near miss record on the dispensary wall was dated November 2023 and contained no entries. A team member struggled to identify recent learning from near misses. The RP supported them by identifying warning labels on shelf edges encouraging team members to apply care when picking medicines with similar names. Team members were aware of some company-led actions taken to reduce risk. A team member explained a common mistake was picking ramipril capsules rather than tablets. A check of the stock location of the two formulations found them stored together in the dispensary drawers. The pharmacy had a process for reporting and learning from mistakes identified after the supply of a medicine to a person, known as a dispensing incident. The pharmacy team was currently unable to access the incident reporting system. The area manager provided confirmation that the last reported incident was September 2023. The GPhC was aware of a recent dispensing incident, but this had not been reported by the team. The pharmacy retained evidence of some of the dispensing incidents that occurred. But it did not have evidence of incident reporting available for some of these. Two examples which were not accompanied by an incident report involved the incorrect strength of a medicine being supplied. A check of stock locations

for the medicines involved found stock layout to be disorderly with boxes of different strengths of the same medicines stored together. This meant there was an increased chance of a similar incident occurring.

The pharmacy had a complaints procedure. And it advertised information to support people in providing feedback about the pharmacy. Pharmacy team members understood how to manage feedback and escalate a concern. The customer service manager was the store's point of contact for pharmacy related matters. They discussed how they managed feedback and responded to concerns. The pharmacy advertised contact information for local safeguarding agencies to the side of the medicine counter. Pharmacy team members understood how to recognise a safeguarding concern, and safeguarding procedures were available. Most team members had completed mandatory safeguarding training in their role. One team member reported they had yet to complete this, they had completed learning in their previous role. They confidently explained how they would recognise and report a safeguarding concern. The RP on duty stated they had completed level two safeguarding training.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. A sample of other pharmacy records examined found the RP record completed in full. The pharmacy held its private prescription register electronically. Entries in the register generally complied with legal requirements. But details of the prescriber were not always recorded accurately or in full. The pharmacy maintained running balances within its controlled drug (CD) register. Pharmacists completed regular physical balance audits of stock against the register. But they did not always act to report any discrepancies found during these balance checks. For example, a balance discrepancy of one medicine had been highlighted in the last three balance checks. The RP on duty during these checks had not followed the pharmacy' procedures correctly to report this. The pharmacy had procedures in place to support the safe handling of people's confidential information. Team members had recently signed an updated declaration confirming they followed the pharmacy's confidentiality processes. The team held personal identifiable information on password protected computers and in staff-only areas. The pharmacy had secure arrangements for disposing of its confidential waste safely.

Principle 2 - Staffing **Standards not all met**

Summary findings

Pharmacy team members are not enrolled on appropriate training relevant to their roles and to the tasks they undertake when working in the dispensary. This increases the chance of mistake occurring during the dispensing process and it increases pressure on the pharmacist's role. Pharmacy team members communicate effectively. They work well together, and they understand how to provide feedback and raise concerns at work.

Inspector's evidence

Two trainee team members worked alongside the RP during the inspection. The pharmacy employed another two trainees. The pharmacy had experienced a high turnover of team members within the last few years. It was currently recruiting for a part-time team member. And it had relied on locum pharmacist cover for the last two years. The pharmacy had recently appointed a pharmacist manager and a second regular pharmacist was also joining the team shortly. The pharmacist manager was in the process of completing their induction training at another pharmacy prior to starting their new role.

One team member reported they had returned to work at the pharmacy six-months ago. They explained they had previously completed medicine counter assistant learning and had been informed they would be beginning new training shortly. The other three team members were enrolled on a GPhC accredited medicine counter assistant course. All team members had worked at the pharmacy for longer than three months. But they did not have immediate access to learning support materials on the day of inspection due to SOPs not being accessible within the pharmacy. The current skill mix increased the working pressure on pharmacists. And it meant pharmacists were both assembling and accuracy checking medicines routinely during the dispensing process.

Pharmacy team members knew how to raise a concern at work. And they explained they would contact a store manager or their area healthcare manager if they required support. Pharmacy team members worked well together, and they regularly shared information with each other to help manage workload. But they did not take opportunities to engage in structured conversations to help share learning following the mistakes they made during the dispensing process. The RP was not aware of any targets for the pharmacy's services. And they were able to apply their professional judgment whilst working at the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They provide a suitable environment for delivering pharmacy services. People using the pharmacy can speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy premises were secure and clean. A store cleaner undertook cleaning tasks when the pharmacy was open. The pharmacy was well maintained, and team members knew how to report maintenance issues. Lighting and ventilation were appropriate throughout the pharmacy. Pharmacy team members had access to hand washing facilities, including antibacterial hand wash and hand sanitiser.

The premises consisted of the medicine counter, a consultation room, and the dispensary. The dispensary was an appropriate size for the work activity taking place. A workbench ran the length of the dispensary, and the team used this space well. It used a workbench at the far-end of the dispensary to hold bags of part-completed prescriptions awaiting items for completion. It attached prescription forms and dispensing labels to these bags to support it in prioritising the completion of these prescriptions when stock arrived. The pharmacy’s consultation room was accessible to people. It was clearly signposted, and it provided an appropriate private space for people to speak with a member of the pharmacy team.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And the pharmacy obtains its stock from reputable suppliers. Its team members use a range of audit trails to support them in providing pharmacy services. And they provide relevant information when supplying medicines to support people in taking their medicines safely. Pharmacy team members apply checks during the dispensing process to ensure medicines are in good condition and are suitable to supply to people. But they do not always store the pharmacy's medicines in an orderly manner which may increase the chance of a mistake occurring.

Inspector's evidence

The pharmacy was signposted from the store entrance to support people in finding it at the back of the store. It advertised its opening times, and it provided a range of helpful information for people. For example, it provided further details about its services in a practice information leaflet. Pharmacy team members knew how to signpost people to other pharmacies or healthcare services when the pharmacy was unable to provide a service or supply a medicine. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were observed asking appropriate questions when responding to requests for these medicines. Team members worked together to monitor requests for higher-risk P medicines, liable to misuse. They brought these repeat requests to the attention of the RP.

The pharmacy team had some processes to support it in dispensing higher-risk medicines safely. It highlighted key information on prescription forms for people on an opioid treatment program to support it in supplying these medicines safely. And it effectively monitored the supply of these medicines and communicated with prescribers and people's key workers when needed. The RP discussed the counselling they would provide to people when handing out medicines with additional monitoring requirements to support people in taking them safely. But the team did not routinely identify these medicines during the dispensing process. A team member knew about recent legal changes requiring the supply of valproate in the manufacturer's original pack and they had an awareness of the valproate Pregnancy Prevention Programme (PPP). The RP discussed the counselling they would provide to people in the at-risk group. But the team did not routinely record these types of interventions on people's medication records to support it in providing continual care.

Pharmacy team members had access to current information to support them in providing pharmacy service safely. For example, up-to-date patient group directions (PGDs) and clinical pathways were available for pharmacists to refer to when providing the NHS England Pharmacy First Service. Training certificates for the pharmacy's newly recruited pharmacist manager were stored with the PGDs. Team members explained the pharmacy provided this service. But the PGDs were not signed and there was no overarching signature sheet available for inspection. The service was not being provided on the day of inspection.

Pharmacy team members used baskets during the dispensing process to help keep individual prescriptions separate. Pharmacists signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. Due to the current skill mix of team members, pharmacists carried out both assembly and accuracy checking tasks during the dispensing process. The RP on duty

was observed applying both mental and physical breaks between completing these stages of the dispensing process. The pharmacy supplied people with records of any medicines the pharmacy owed to them. It kept copies of prescriptions containing owed medicines, and team members completed daily checks of medicine availability to support the pharmacy in supplying owed medicines in a timely manner. It supplied medicines in the manufacturer's packaging whenever possible and supplied patient information leaflets to support people in taking their medicines safely.

The pharmacy obtained its medicines from licensed wholesalers. But it did not always store medicines neatly on the pharmacy's shelves. Several foil blisters containing medicines out of the manufacturers original packaging were found during random checks of dispensary stock. And different strengths of the same medicine were commonly found stored together, this increased the chance of a mistake involving a strength error occurring. The pharmacy kept CDs in an orderly manner within a secure cabinet. Medicines inside the pharmacy's fridge were stored neatly, but a bottle of milk was stored alongside medicine within the fridge. Fridge temperature records showed that the fridge was generally operating within the required range of two and eight degrees Celsius. It had exceeded eight degrees Celsius on two recent occasions, the team had not annotated the record with a reason for this or to demonstrate any additional monitoring applied on these dates. And not all team members were aware of the required operating temperature of the fridge. The RP acted immediately to support team members in monitoring the fridge temperature moving forward by applying a notice to the fridge detailing the required temperature range.

Pharmacy team members stated they carried out checks of stock medicines during quieter periods. But they did not keep a record of the checks they made on the expiry dates of medicines. A random check of stock found out-of-date adrenaline ampoules in the consultation room, and a bottle of liquid medicine with a shortened expiry date after opening was not annotated with any information about the date it was opened. This meant team members could not make appropriate checks to ensure it was safe to supply to people. These medicines were removed and brought to the attention of the RP for safe disposal. Pharmacy team members were observed checking expiry dates during the dispensing process to help reduce the risk of supplying a date expired medicine. The pharmacy had appropriate medicine waste bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy team received medicine alerts by email. And team members demonstrated an effective process for acting on these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And its team members team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Pharmacy team members had access to reference resources to support them in obtaining information. They had access to the internet, and they used passwords and NHS smart cards when accessing people's medication records. The pharmacy protected information on computer monitors from unauthorised view through the layout of the premises. It stored bags of assembled medicines safely in a designated area within the dispensary.

The pharmacy team used a range of clean and appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicines and counting triangles for counting tablets. It clearly identified separate equipment for measuring and counting higher-risk medicines to avoid any risk of cross contamination. The pharmacy held the equipment required to provide its consultation services neatly within the consultation room. This equipment was from recognised manufacturers, and it was clean and ready to use.

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.