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: 14/11/2024

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 consultation services including the New Medicine Service, blood pressure checks, and the NHS Pharmacy First Service.

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 effectively identifies and manages the risks for the services it provides. Its ongoing monitoring processes help to support its team members in learning from the mistakes they make during the dispensing process, to reduce the risk of similar mistakes occurring. The pharmacy keeps people's private 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. A learning report from the end of October 2024 indicated that several team members needed to complete some or all of this learning. The general store manager explained that this was being addressed and provided assurance that some progress had been made since the generation of the report. The responsible pharmacist (RP) on duty was a locum pharmacist. They were required to share details of their identification, training records and provide assurances that they were familiar with the pharmacy's SOPs prior to booking a shift at the pharmacy. Team members on duty were observed working in accordance with the pharmacy's SOPs. For example, seeking clarification of people's names and addresses prior to handing out bags of assembled medicines. A team member explained clearly what tasks they could not complete if the RP took absence from the pharmacy.

Pharmacy team members acted to report the mistakes they made during the dispensing process, known as near misses. Team members usually discussed their mistakes on a one-to-one basis with pharmacists due to shift patterns in the pharmacy. The regular pharmacists reviewed these records weekly to help identify trends and to document the learning and risk reduction actions required of the team. And they encouraged team members to keep themselves up to date with the agreed actions required to reduce risk. The pharmacy had a process for reporting mistakes identified after a person had received the medicine, known as dispensing incidents. This process included reflecting on the mistake and identifying steps required to minimise the risk of a similar incident occurring. The general store manager provided evidence of incidents being brought to their attention to ensure the team had taken appropriate action to learn from them. The reporting system was used to record other adverse incidents such as acts of aggression directed at team members and any incidents involving controlled drugs (CDs). The reporting system was accessible to employed team members. The RP on duty was a locum pharmacist, and as such could not access the reporting system. They demonstrated the steps they took to leave a written record of an incident, and their own investigation notes when working as the RP. They left this note for the regular pharmacist's attention to support the pharmacy's formal incident reporting processes.

The pharmacy team was required to complete some daily and weekly monitoring checks. It recorded these checks within its communication book. These checks included confirming record keeping requirements and safety processes were being followed. But a sample of completed checklists showed that sometimes a task would be recorded within the checklist as completed, but the specific record

would show it had not been completed as required. For example, records of the checks made on 8 November 2024 confirmed the RP record had been completed and fridge temperature checks had taken place. But these specific records had not been completed on that date. This indicated there was some complacency in the approach to ongoing monitoring and as such there could be missed opportunities to identify risk.

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. Pharmacy team members understood how to recognise a safeguarding concern. They had access to procedures and contact information for local safeguarding agencies. The RP had completed level three safeguarding training and discussed how they would respond to and act on a concern. For example, by contacting prescribers' directly if they had any concerns about the suitability of a prescribed medicine for a person.

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 contained several gaps where pharmacists had not made an entry into the record. The pharmacy held its private prescription register electronically. A sample of entries in the register was checked and complied with legal requirements. The pharmacy generally held its CD register as legally required. But pharmacists did not always enter the address of the wholesaler when entering the receipt of a CD in the register as required. The pharmacy maintained running balances in the register. And pharmacists completed regular physical balance audits of stock against the register. The pharmacy had procedures in place to support the safe handling of people's confidential information. The team was observed treating people's confidential information with care. It 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 met

Summary findings

The pharmacy employs people with the knowledge and skills required to provide its services safely. Pharmacy team members work together well, and they communicate effectively. They engage in learning relevant to their roles and they receive regular support to help ensure they progress through training courses. Pharmacy team members understand how to raise concerns at work. And they engage in some discussions about patient safety and workload management.

Inspector's evidence

A trainee dispenser was on duty alongside the RP throughout the inspection. The pharmacy also employed two regular pharmacists, another two trainee dispensers and two trainee medicine counter assistants. Team members worked flexibly when required to cover both planned and unplanned leave. The reliance on locum pharmacists had reduced significantly in the six months since the last inspection of the pharmacy. The employment of the two regular pharmacists in Spring 2024 had provided stability to the team and had introduced some consistency for people accessing pharmacy services.

The team member on duty felt they were progressing well in their training role. Team members received support from the regular pharmacists when completing their learning. For example, a sample of learning records in the pharmacy showed pharmacists provided written testimonials as supportive evidence of trainee's knowledge and skills following the completion of key tasks. Team members completed some learning at home in their own time, and some at work. They completed mandatory learning on a range of subjects such as information governance, safeguarding and manual handling to support them in working safely in the pharmacy. The RP had not discussed the need to meet specific targets when working at the pharmacy. All team members were expected to contribute to providing the pharmacy's services and the RP discussed how they applied their professional judgement when working.

Both team members on duty were observed working well together, dispensing workload was up to date and managed effectively. Team members used a communications book to share learning, including structured feedback and actions required following patient safety reviews. The pharmacy had a whistle blowing policy. Its team members knew how to raise a concern at work. Concerns would be raised in the first instance with a regular pharmacist before being escalated to the store manager and area healthcare manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, organised, and secure. They provide a suitable environment for delivering pharmacy services. People using the pharmacy are able to 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, in the presence of team members. And team members completed regular cleaning and organisation tasks to keep the premises in good order. The pharmacy was maintained appropriately, and team members knew how to report maintenance issues. Lighting and ventilation arrangements 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. 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. The pharmacy’s consultation room was accessible to people, it was clean and clearly signposted. The room provided a professional space for people to speak with a member of the pharmacy team in private.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises details of its services and makes them accessible for people. It obtains its medicines from reputable sources, and it mostly stores them safely and securely. It conducts regular checks of its medicines to help ensure they remain safe to supply to people. The pharmacy manages its services appropriately. And its team members provide relevant information when supplying medicines to help people take their medicines safely.

Inspector's evidence

The pharmacy was signposted from the supermarket 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. It also displayed clear signage asking people to treat the team with respect. Pharmacy team members knew 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. For example, a team member asked the right questions to establish that a request for a higher-risk P medicine, liable to misuse was a repeat request. They politely explained to a person why they needed to refer the request directly to the pharmacist. The RP made themselves available to speak to the person about why the medicine was indicated for short-term use only. The pharmacy had supportive information available to team members to allow them to comply with medicine-related pregnancy prevention programmes (PPPs). The RP provided details of the conversation they would have with people when dispensing valproate, including providing advice to men taking valproate. The RP explained they generally recorded this information on people's medication records. But not all pharmacists routinely took the opportunity to record these kinds of interventions on people's medication records to support continual care.

Pharmacy team members had access to current information to support them in providing pharmacy service safely. For example, current patient group directions (PGDs) and clinical pathways were available for pharmacists to refer to when providing the Pharmacy First Service. Some information held with the PGDs provided evidence of learning that the regular pharmacists had completed to provide these services. The team kept appropriate records of the medicines it dispensed to people on opioid treatment programmes. This allowed team members to identify gaps in treatment and report these through to the substance misuse team effectively. The team highlighted some important information on prescriptions when dispensing higher-risk medicines, such as the strength of the medicine. This prompted extra care when dispensing these medicines. A team member discussed the importance of checking the date on the prescription before handing out a prescription, to ensure the prescription remained legally valid.

Pharmacy team members used baskets during the dispensing process to help keep individual prescriptions separate. They signed medicine labels to show who had been involved in the dispensing process, and to identify who had performed the final accuracy check of the medicine. The pharmacy supplied people with records of any medicines it owed to them. It kept copies of prescriptions

containing owed medicines, and team members completed regular checks of medicine availability to support the pharmacy in supplying owed medicines in a timely manner. The team provided examples of communicating with local surgeries when a medicine was not available due to a stock shortage. This helped to ensure prescriptions for alternative medicines could be issued prior to a person running out of their medicine.

The pharmacy obtained its medicines from licensed wholesalers. It stored its medicines neatly. But it did not always store medicines within their original packaging. A small number of medicines were held in white boxes with a label on identifying the contents inside and the expiry date of the medicine recorded on the box. Several boxes contained blister strips of medicines with no batch numbers present on the strips. These boxes were removed from stock and segregated for safe destruction. And a conversation highlighted the need to ensure the batch numbers of medicines held in stock was available to support the team in responding to queries and alerts about medicines effectively. The pharmacy generally kept its CDs in an orderly manner within a secure cabinet. A one-off incident found during the inspection highlighted the need to ensure particular care was taken when transferring medicines into the CD cabinet. Medicines inside the pharmacy's fridge were stored neatly. The team kept a fridge temperature record and it generally used this to monitor the operating temperature range of the fridge. There were several gaps in the record where team members had not taken the opportunity to record the operating temperature range. The team had escalated a concern about its current fridge running at a slightly higher temperature than required. This had been escalated and acted upon and the pharmacy had received a new fridge.

Pharmacy team members conducted checks of stock medicines during quieter periods. They kept a record of the checks they made on the expiry dates of medicines. A random check of stock found no out-of-date medicines. The pharmacy had appropriate medicine waste bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy team received medicine alerts by email. And the team demonstrated an effective process for acting on these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it requires to provide its services safely. Its team members take care to protect people's confidential information when using the equipment.

Inspector's evidence

Pharmacy team members had access to a range of reference resources, they accessed most of these digitally. 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 standardised 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. It stored equipment for consultation services neatly within the consultation room. But a check of this equipment found some date-expired plasters. These were removed and given to a team member for safe disposal. Other plasters, within their expiry date were readily available for use and stored with equipment used to support the delivery of flu vaccination service. A conversation highlighted the importance of extending stock management tasks, such as date checking to include the consultation room. The pharmacy's electrical equipment was free from wear and tear, some stickers on electrical cables indicated the equipment was last subject to safety checks in March 2023.

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.