General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Cambridge Road Industrial Estate, Milton, CAMBRIDGE, Cambridgeshire, CB24 6AY

Pharmacy reference: 1029209

Type of pharmacy: Community

Date of inspection: 08/11/2022

Pharmacy context

This busy community pharmacy is located within a large supermarket on the outskirts of Cambridge. There is ample parking on site for customers wanting to use the pharmacy's services. Due to current staffing arrangements, the pharmacy offers a limited range of services which mainly involve dispensing NHS prescriptions and selling medicines over the counter. The pharmacy does not have a regular pharmacist in post at present.

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	1.1	Standard not met	The pharmacy doesn't manage some of its risks adequately, meaning it cannot be sure that its services are always safe for people to use.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy team does not have enough suitably trained staff or staff doing the right training to manage its workload effectively.
		2.2	Standard not met	Some team members have been completing dispensing tasks for more than three months without being started on accredited training to do this.
3. Premises	Standards not all met	3.5	Standard not met	The consultation room is not kept in an appropriate condition for people to use to receive healthcare services.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot show that some medicines needing refrigeration are always stored at the right temperatures.
5. Equipment and facilities	Standards not all met	5.1	Standard not met	The pharmacy does not have suitable equipment available to make sure its medicines fridges are keeping medicines at the right temperatures.

Principle 1 - Governance Standards not all met

Summary findings

A lack of management oversight and support in the pharmacy means that some risks are not fully managed to protect people's health and wellbeing. Issues involving the state of some of the equipment and the premises are not resolved promptly. And some staff are undertaking tasks for which they aren't doing the right training. However, the pharmacy's team members try to learn from their mistakes to make their services safer. And the pharmacy keeps people's information safe. It keeps the records it needs to by law, and these are largely complete.

Inspector's evidence

Pharmacy services were supported by written standard operating procedures (SOPs) issued by head office and these were reviewed regularly. The pharmacy's team members said they had read the SOPs and that the store's office had a record about this. Prescription labels were initialled at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. Designated areas of the pharmacy were used for separate tasks such as dispensing and checking prescriptions to reduce the risk of distractions.

Staff tried to record dispensing mistakes they made that were spotted before the medicines were handed out (referred to as near misses). The records viewed showed some mistakes had been written down in October 2022 and previous months. There was some limited evidence of staff considering how a mistake had happened and how to prevent similar in the future. They mentioned learnings from mistakes and that some medicines with similar names had been more clearly separated to prevent picking errors such as quinine and quetiapine. And strengths of levothyroxine and amlodipine had also been separated because their packaging was very similar. The company had a procedure for recording, reporting, and reviewing dispensing mistakes that reached people and staff were aware of this.

Members of the team could explain what they could and couldn't do when a pharmacist was not present. They also knew the types of medicines that could be liable to abuse and under what circumstances they needed to refuse to supply or refer requests for these medicines to the pharmacist for further advice. Staff members wore uniforms so they could be readily identified by members of the public. The pharmacy had a complaints procedure. Staff explained that they tried to resolve complaints in-store and would refer people to the pharmacist or to customer service where needed.

There were written procedures and staff training about protecting confidentiality. The staff had completed training about the General Data Protection Regulation. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. The IT system was password protected. Staff used their own NHS smartcards and passwords to access electronic prescriptions and did not disclose passwords to each other.

The pharmacist on duty had completed level 2 training about safeguarding and had some understanding of what to do if they had concerns about the wellbeing of a vulnerable person. There was a chaperone policy for using the consultation room.

The pharmacy had current professional liability and public indemnity insurance, confirmed by head

office. Records about controlled drugs (CDs) were kept and complied with legal requirements. CD running balances were kept and checked for accuracy regularly. The pharmacy had a separate register for patient-returned CDs. The stock of a CD chosen at random agreed with the recorded balance. Records about the responsible pharmacist (RP) were kept and the correct RP notice was displayed where members of the public could see it. Private prescriptions were recorded electronically. A recent entry checked did not contain the correct information about the prescriber. The trainee dispenser said he would look into this for future entries.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy’s team members work well together but they are struggling to manage their workload effectively. There is a lack of oversight of how the pharmacy is running and limited support for the team members. Some team members are undertaking tasks not covered by their current training. And others are not able to complete the accredited training they have started. Pharmacy team members are not always able to answer phone calls in the pharmacy. This could mean that people with urgent queries about medicines, including healthcare professionals, are not able to speak to someone in the pharmacy when needed.

Inspector's evidence

The pharmacy team consisted of one trained dispenser, one trainee dispenser, three trainee medicine counter assistants (MCAs) who were involved in dispensing tasks, and a further trainee MCA who had transferred into the pharmacy three days prior to the inspection. The pharmacy did not have any employed pharmacists in post but did have a few regular locum pharmacists who provided responsible pharmacist cover. Staff said the pharmacy had some difficulty in finding pharmacist cover at times and had needed to close on occasions because of this. Most recently, the pharmacy had not been able to open on the Sunday prior to the inspection.

The team members were doing their best to cope with the workload during the inspection and they worked closely together. But the pharmacy was behind on dispensing repeat prescriptions and some people had extended waits for their medicines. The pharmacy phone was often left to ring unanswered because staff were trying to deal with prescriptions and queries from people at the pharmacy counter. Team members said that it had become more challenging serving customers at the pharmacy since Covid. Some of the team described significant abuse their colleagues had received from customers, and this had been upsetting.

Most of the staff were on training courses arranged for them by the company but it was taking them longer to complete these than expected. And most of the trainee MCAs were also carrying out dispensing tasks such as picking medicines against prescriptions despite not being on a course which covered this. Team members said they didn’t get any time at work to do their pharmacy training. And they said that they hadn’t been able to progress in some of their training because there was no-one who could supervise this appropriately. When asked, members of the team said they didn’t have regular reviews to check how they were progressing in the pharmacy. However, team members described how information was shared amongst the team using a group chat app. They used this facility to share incidents and learnings and to try to make sure other members of the team received useful handover information. Team members could also make suggestions to each other to improve how the pharmacy worked. An example given was about how part-dispensed prescriptions were now stored in a designated area, off the floor. This made it easier to identify these prescriptions and reduced the risk of trips.

Principle 3 - Premises Standards not all met

Summary findings

Parts of the pharmacy's premises, in particular the consultation room, are not maintained properly and do not reflect the cleanliness expected in a healthcare setting. However, the premises are secure against unauthorised access, and they are accessible to people with mobility problems.

Inspector's evidence

The premises were large enough for the activities currently undertaken. And it had enough bench space to help with safe dispensing routines. The premises were mostly kept clear of slip or trip hazards. Staff explained they had occasional help from in-store cleaners, but the pharmacy team didn't get much time to do cleaning due to their workload. Some parts of the dispensary around the sink area were cluttered with used cups. And some lower open drawers were very dusty. Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken.

The pharmacy had a consultation room to one side of the main area and people could have a private conversation about their healthcare in this room. But the room was cluttered and in a poor state of repair and presented a poor impression to anyone using the room. A cupboard door had been taken off its hinges and left in the room and the sink at the back of the room was filthy.

The pharmacy team members had access to staff facilities in-store including rest areas and toilets. The premises could be secured outside of opening hours and were accessible to people with mobility issues or those with prams or wheelchairs. The dispensary was clearly separated from the shop area and access by the public was suitably restricted. Pharmacy-only medicines were kept out of reach of the public so their sales could be supervised appropriately. Dispensed medicines were protected from public view.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy generally dispenses prescriptions safely though it is currently behind on dispensing repeat prescriptions, and this is putting some pressure on the team. The pharmacy cannot show that some medicines needing refrigeration are always stored at the right temperatures. The pharmacy team is aware of the need for extra care when supplying certain medicines which may be higher risk. But prescriptions for these medicines are not always highlighted. So, it may be harder for team members to give people all the information they need to take their medicine safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The main entrance door to the store was power assisted and level with the pavement and the supermarket had onsite parking for people. The pharmacy generally provided a very limited range of services. The pharmacy had had to close on occasions due to the lack of pharmacist cover. To reduce the risks to people receiving daily instalment supplies of certain medicines, most of these people had been transferred to other local pharmacies to access this service.

The pharmacy team members explained they were running behind on dispensing regular repeat prescriptions due to staffing issues. This meant that, instead of having prescriptions ready for people to collect when they came to the pharmacy, the pharmacy was often dispensing these medicines when a person attended the pharmacy. This was creating additional pressure for the team and added waiting times for people using the pharmacy. The pharmacy had considered closing early on occasions to try to catch up with the workload. But the open nature of the pharmacy premises made it difficult to explain to people why it wasn't serving people during those times and would cause further complaints.

Dispensing being carried out during the visit was done in an orderly way. All dispensed items were checked by the responsible pharmacist and the dispensed medicines were subject to a further check just before handing out. Baskets were used to keep prescriptions for different people separate. Part-dispensed prescriptions were kept in a separate location and the team members tried to make sure that these were completed as soon as stock arrived. When asked, some staff members knew about some of the checks to make when they gave out prescriptions for warfarin. This included asking people about their recent blood tests. But these prescriptions were generally not flagged to make sure this happened every time. And there wasn't a similar process in place for prescriptions for methotrexate. This could mean the pharmacy misses some opportunities to provide people with additional advice when they collect their medicines. When asked, the team members knew how long prescriptions for CDs were valid for.

The team members had a basic understanding that prescriptions for valproate needed additional care when supplying to people who might become pregnant. The stock packs available had the warning cards and alert stickers attached. But the team did not have any spare cards or alert stickers to use if a smaller quantity needed to be supplied. And the pharmacy didn't flag these prescriptions to make sure the pharmacist would check that people were using adequate contraception. The pharmacy team was advised how to order replacement cards and stickers and the pharmacist suggested they could attach 'see pharmacist' stickers to these prescriptions in future to make sure the right checks were made each

time.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicines were largely stored in dispensary drawers in a tidy way. As noted in principle five, one of the pharmacy's fridges did not have a working maximum and minimum thermometer and the temperature showing on the thermometer that was in place did not fall within the recommended range for medicines requiring refrigeration. So, the pharmacy could show that these medicines were always stored in appropriate conditions.

Date checking was carried out on a three-month cycle and recent records about this were up to date. Medicines were kept in appropriately labelled containers and there were no date-expired medicines found amongst dispensing stock when a sample of items was checked at random. Out-of-date medicines and patient-returned medicines were transferred to designated bins and stored separately from dispensing stock. Appropriate arrangements were in place for storing CDs securely. The pharmacy had a process to receive and act on drug recalls and safety alerts. It was notified of these by its head office and there was a system in place to make sure these were responded to promptly.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy doesn’t have all the equipment it needs to provide its services safely. It cannot show that its medicine fridges are always operating correctly. And there is some scope to make sure its equipment is cleaned more effectively.

Inspector's evidence

One of the pharmacy’s two medicines fridges was equipped with a maximum and minimum thermometer. A similar thermometer for the other fridge was broken. The fridge temperature displayed on the working thermometer at the start of the inspection was -10.8 degrees Celsius. The probe was pushed to the back wall of the fridge and was in direct contact with the fridge wall. This was repositioned during the inspection and the inside temperature dial changed. Stock was checked and did not appear to be frozen. The temperature was rechecked later in the inspection and was 2.5 degrees Celsius. Staff said they had had problems previously with erroneous readings and had tried to order replacement thermometers, but none had been received.

The pharmacy had measuring equipment of a suitable standard. But some of the glass measures needed descaling and the tablet counting triangle was covered in dust. This could increase the chance of cross-contaminating other medicines. It had a range of up-to-date reference sources available to assist with clinical checks and other services. All portable electrical equipment appeared to be in good working order. The pharmacy’s patient medication records were kept secure and computer screens in the pharmacy could not be viewed from the shop floor. The pharmacy had a cordless phones and team members could make phone calls out of earshot of waiting customers if needed.

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.