General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Barford Road, St Neots, Cambridgeshire, PE19 2SA

Pharmacy reference: 1029261

Type of pharmacy: Community

Date of inspection: 18/08/2023

Pharmacy context

This community pharmacy is located within a large supermarket on the outskirts of St. Neots. It is open from 8am to 8pm Monday to Saturday and 10am to 4pm on Sundays. Most of its current activity is dispensing NHS prescriptions and it sells some medicines over the counter. It provides the NHS New Medicine Service and Community Pharmacist Consultation Service. It also provides substance misuse treatment. This was a reinspection visit following a previous inspection which found the pharmacy was not meeting all the standards for registered pharmacies.

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 has made improvements since the last inspection to make sure potential risks are managed adequately. There is some evidence that the pharmacy team members learn from mistakes to help make services safer. The pharmacy's team members understand their roles and responsibilities and they keep people's information safe. The pharmacy generally keeps the records it needs to by law. But the details for private prescriptions are not always recorded correctly and this could make it harder to handle queries in future.

Inspector's evidence

The pharmacy team had access to electronic standard operating procedures (SOPs) issued by head office to help deliver services safely and these were reviewed regularly. There was a process to make sure team members read and understood the SOPs relevant to their roles. 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. Baskets were used to keep prescriptions for different people separate. The responsible pharmacist was observed managing the workload by prioritising urgent prescriptions and giving realistic waiting times to people. The pharmacy manager explained the pharmacy was moving to a new system whereby people collecting repeat prescriptions would be asked to wait until they received a text from the pharmacy before coming to collect their medication. This was to reduce pressure on the pharmacy team and improve the service for customers.

There were record sheets available to write down dispensing mistakes the team members made that were spotted before the medicines were handed out (referred to as near misses). The most recent records were from the week of the inspection. The records made contained limited information about the mistake and could have included more detail about why the mistake might have happened or any learnings to prevent similar happening again. There was also a process to record and report mistakes which reached people (known as dispensing errors) to head office. And to share learnings from previous mistakes with the team. Some medicines with similar names or similar packaging had been more clearly separated and the storage areas highlighted to prevent picking errors. The pharmacy manager explained the team was being particularly vigilant at present about generic medicines from Teva as the packing all was very similar.

Members of the team could explain what they could and couldn't do when a pharmacist was not present. There was also reference information in the dispensary to help staff know what to do if this happened. Team members could explain the restrictions on sales of painkillers containing codeine and would refer repeat requests to purchase these to the pharmacist. The pharmacy did not sell codeine linctus over the counter.

The pharmacy had a complaints procedure. The team was aware that there were long queues at time which impacted the experience for people using the pharmacy. Recruitment activity was underway and the team was trying to keep people informed of how long prescriptions would take to dispense.

The pharmacy had current professional liability and public indemnity insurance. Records about

controlled drugs (CDs) were kept and generally complied with legal requirements; there were a small number of headers missing. CD running balances were kept and checked for accuracy regularly. Manufacturer's overages were recorded correctly. The stock of a three CD chosen at random agreed with the recorded balances. The pharmacy manager was aware of who to inform if there was a discrepancy found. The pharmacy had a separate register for patient-returned CDs. The responsible pharmacist (RP notice) was displayed clearly and showed the correct details for the RP on duty. Records about the RP were kept and were complete. Records about private prescriptions were kept electronically. Recent entries checked did not always include the correct prescriber's details or the correct date on which the prescription was written. The pharmacy manager said they would ensure these records were made correctly in future.

There were written procedures and staff training about protecting confidentiality. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. There was a data privacy notice poster displayed where people could see it. The IT system was password protected.

Team members including the pharmacy manager had completed level 2 safeguarding training. The pharmacy manager was not aware of any incidents of concern about the welfare of a vulnerable person but knew how to report one if it happened.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team is just about managing to keep on top of its dispensing activities and other routine tasks. The pharmacy manager is currently recruiting additional staff to better manage the workload. The pharmacy's team members work well together and are enrolled on the right training for their roles. And they are provided with additional training materials to help keep their skills and knowledge up to date. They know when to refer queries to the pharmacist, so people get the right advice and information.

Inspector's evidence

The staffing profile had changed over the past year or so and quite a few experienced team members had left. The current pharmacy team consisted of the pharmacy manager who provided most of the RP cover, an accuracy checking technician (ACT), a trained dispenser, and two medicine counter assistants (MCA), one of whom had just started dispenser training. The team members were coping with the workload during the inspection, and they were observed working closely together. The MCAs referred queries to the RP where needed. The team members were currently up to date with routine dispensing.

There were occasions each week when no dispenser support was available. This led to longer waiting times for people as the pharmacist had to self-check their own work. The pharmacy manager was currently recruiting for additional dispensers and had been given approval to use locum dispensers in the meantime. The pharmacy manager described how services were restricted to reflect the current staffing arrangements and how she felt able to exercise her professional judgements in making these choices.

Members of staff had completed or were enrolled on accredited training courses relevant to their roles. Those team members on accredited training courses were allocated an hour per week to complete training at work. To help keep their skills and knowledge up to date, team members also had access to training modules provided by the company, some of which were considered mandatory. The team members were prompted about any new or mandatory training and its completion was tracked.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally adequate for the safe provision of pharmacy services, and they are kept clean and tidy. The pharmacy is kept secure when the pharmacy is closed. And people can have a conversation with members of the pharmacy team in a private area and won't be overheard.

Inspector's evidence

Overall, the premises were large enough for the activities currently undertaken and were kept reasonably clean and tidy. The dispensary had sufficient space to help with safe dispensing routines and sections of dispensing bench were reserved for specific parts of the dispensing process to reduce risks. However, some of the dispensary drawers were broken and meant it was hard to find stock and carry out date-checking and stocktake routines easily. The pharmacy manager said this had been raised within the business and remedial action was imminent.

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 just off the retail area which was reasonably large and well kept. It had lockable storage and a computer terminal which supported its use for services. People could have a private conversation about their healthcare in this room. The pharmacy team members had access to rest areas and hygiene facilities in the main store.

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. Dispensed medicines were kept away from public view to protect people's private information and people visiting the pharmacy could not see information on the pharmacy's computer screens.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally provided safely though waiting times for people are sometimes longer than the pharmacy would like. The pharmacy team tries to make sure the medicines it supplies are date checked and are removed and disposed of at an appropriate time. But the damaged drawers in the dispensary make this harder to achieve. The pharmacy team is aware of the need for extra care when supplying certain medicines which may be higher risk, including medicines containing valproate. And the pharmacy manager has provided training to the team since the last inspection to make sure the team is fully aware of the advice to give to people when supplying higher-risk medicines.

Inspector's evidence

The pharmacy's opening hours were displayed. The entrance doors to the supermarket were power assisted and level with the pavement and the aisles were wide enough to accommodate people with prams or wheelchairs. There was an induction hearing loop available, with instructions for people wishing to make use of this equipment. There was ample parking for people on site.

The pharmacy team members were currently up to date with dispensing activities. Dispensing being carried out during the visit was done in an orderly way. All dispensed items were accuracy-checked by the RP and were subject to a third check just before handing out to people. Baskets were used to keep prescriptions for different people separate.

The team members understood 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. The pharmacy also had spare cards and alert stickers to use if a smaller quantity needed to be supplied in a plain box. Team members knew where to apply dispensing labels so as not to obscure safety information on the original packs. The pharmacy manager explained how they would check that people were using adequate contraception. The pharmacy did not currently supply valproate medicines to anyone who needed to be on a Pregnancy Prevention Programme. The pharmacy also had additional safety literature to give to people when supplying other higher-risk medicines including methotrexate.

The pharmacy manager provided the Community Pharmacist Consultation Service. The pharmacy's longer opening hours and closure of other local pharmacies had meant it was seeing more referrals to this service. The pharmacy manager explained that some of the referrals were not within scope, and the pharmacy had had to signpost patients back to NHS 111 on occasions. These were largely for treatment of symptoms that needed further investigation or requests for emergency supplies of CDs. Where possible, the pharmacy manager had used feedback mechanisms to indicate the weaknesses in the referrals to reduce similar events occurring.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. Medicines were stored in dispensary drawers and on shelves in the dispensary. Medicines for dispensing were kept in appropriately labelled containers. CDs were stored securely. There were two medicines found amongst dispensing stock which were beyond their use by date. The pharmacy manager accepted the pharmacy team was a little behind on its date checking routines and

would act on this straight away. In the interim, date checks at the point of dispensing would be undertaken to prevent the supply of date-expired medicines to people. The medicines fridge temperatures were monitored and were kept within the required range for medicines requiring refrigeration. No extemporaneous dispensing was carried out.

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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it has systems in place to make sure its equipment is maintained correctly.

Inspector's evidence

The pharmacy had measuring equipment of a suitable standard. Some of the glass measures were reserved for measuring specific types of medicines to prevent cross-contamination. These were kept clean. The pharmacy had access to online reference sources to assist with clinical checks and other services. It also had the right equipment to assist the safe disposal of medicines and sharps waste and kept these out of reach of the public. All portable electrical equipment appeared to be in good working order and testing of this was arranged by head office. The pharmacy had cordless phones so team members could make phone calls out of earshot of waiting customers if needed. The pharmacy's patient medication records and computer screens in the pharmacy could not be viewed from the shop floor. The blood pressure meter was replaced regularly to help make sure the results it provided to people were reliable.

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.