

Registered pharmacy inspection report

Pharmacy Name: Well, Tesco Superstore, Transit Way, Honicknowle,
PLYMOUTH, Devon, PL5 3TW

Pharmacy reference: 1030872

Type of pharmacy: Community

Date of inspection: 29/10/2019

Pharmacy context

The pharmacy is located in a shopping precinct in Plymouth, next to a large supermarket. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers services including Medicines Use Reviews (MURs), the NHS New Medicines Service (NMS) and flu vaccinations.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not resolve maintenance issues promptly. The fixtures and fittings are dated and people can enter the dispensary easily.
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 identifies and manages its risks appropriately. It reviews its practices to make them safer and more effective. Team members usually record their errors and learn from them to stop them happening again. Staff are clear about their roles and responsibilities. They work in a safe and professional way. The pharmacy asks people for their views. It has adequate insurance for its services. The pharmacy generally keeps up-to-date records as required by the law. The pharmacy keeps people's private information safe and explains how it will be used. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had appropriate processes in place to monitor and reduce risks. Near misses were usually recorded online and contained details of the error and a brief reflection on the cause and the learning points. The branch manager said that the time taken to access Datix, the online system to record near misses, did limit the number that were reported. Dispensing incidents were also recorded on Datix and included a more detailed analysis of the cause. When errors were identified, they were discussed as a team to identify the potential contributing factors. A recent incident had been reported where a prescription had been sent for dispensing at the off-site hub with incorrect directions on the label. The hub had returned the prescription with the stock and a large note was attached highlighting the labelling error so that the pharmacy team could correct it. Errors were reviewed in a monthly patient safety report completed by the manager and reviewed by the regular responsible pharmacist (RP). A company produced 'Share and Learn' document was discussed as a team during a monthly patient safety meeting.

Standard operating procedures (SOPs) were held online up to date and were regularly reviewed. A record of which SOPs had been read by staff was held on each individual's 'The Hub' account. The manager could access a report to track compliance. The RP checked understanding of SOPs through observation and questioning. She provided additional coaching as required. A dispenser could describe the activities that could not be undertaken in the absence of the RP. Staff had clear lines of accountabilities, were clear on their job role and wore name badges. The pharmacy had a business continuity plan in place, which was held online. The manager described how, before implementing a new service, she would ensure the pharmacy would be able to accommodate the work, and that it would be applicable to the local population. She would review staffing levels to ensure provision of the service could be maintained and would check that she and her staff had access to the appropriate tools and training to provide the service.

Feedback was obtained by a yearly community pharmacy patient questionnaire (CPPQ) survey. 70.7% of respondents had rated the pharmacy as very good or excellent overall. 34% of respondents had said that the comfort and convenience of the waiting area was not adequate, but the pharmacy had not yet taken steps to make improvements. A complaints procedure was in place and was displayed in the retail area.

The pharmacy had appropriate indemnity and liability insurances in place. Records of the RP were maintained appropriately. The correct RP certificate was displayed although it was obscured by stock on the shelves in front of it. Controlled drug (CD) registers were generally maintained appropriately,

although the address of the supplier was not always completed. Balance checks were usually completed weekly. But a random stock balance check of Equasym XL 20mg capsules was found to be accurate. Patient returned CDs were recorded in a separate register and were destroyed promptly. Records of private prescriptions and emergency supplies were made in a book and were mostly in order. Specials records were maintained but the certificates of conformity did not always contain all legally required details.

All staff had completed training on information governance and the General Data Protection Regulation and had signed the associated policies. Patient data and confidential waste was dealt with in a secure manner to protect privacy. But the bag labels containing people's private information were clearly visible to people waiting to be served at the counter. Smart cards were generally used appropriately but one was inserted into a computer belonged to member of staff who was not present during the inspection. Written consent was obtained where possible before summary care records were accessed. If written was not possible, verbal consent was obtained.

All staff were trained to an appropriate level on safeguarding. The RP had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training, and the remaining staff completed yearly safeguarding training on the company 'e:Expert' system. Local contacts for the escalation of concerns were accessed online.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy usually has enough staff. Team members sometimes work under pressure but manage to keep on top of the workload. Team members are appropriately trained for their roles. They keep their skills and knowledge up to date. But they often complete their learning at home. Team members suggest and make changes to improve their services. They communicate well with each other.

Inspector's evidence

Staffing levels were adequate on the day of the inspection. In addition to the RP, there was a pharmacy technician who was the branch manager, and two dispensers. When one dispenser finished her shift, the queues increased and the team became under considerable pressure. The team felt that they were often working under stress. A high number of the items dispensed were 'walk-ins' and there were often queues in the shop. The manager said that the pharmacy often caught up with their work in the evenings when they were open but had less customers. The current RP was leaving the pharmacy in the coming days to move to another branch and locum pharmacists were booked for the foreseeable future. The manager was concerned about the impact that this would have on workload. Rotas for the support staff were completed in advance to plan for absences, which were usually covered rearranging shifts, or by part-time staff increasing their hours. In an emergency, the manager would call on support from other local stores.

The pharmacy team reported that they often did not have a chance to complete required learning during working hours, and often completed packages in their own time. Resources accessed included compulsory SOPs, CPPE packages and optional advanced learning on the company e-Learning portal. Staff were set yearly development plans and received regular ad-hoc feedback on their performance. Staff were seen to offer appropriate advice when selling medicines over the counter and were observed referring to the pharmacist when additional information was required.

The manager felt able to raise concerns and give feedback to the area manager. She worked well with the RP and they discussed ideas to make improvements together. Team members were aware of the escalation process for concerns and a whistleblowing policy was in place. A dispenser described that she felt supported by the store manager and the stores in the wider area. The RP said that she targets set were challenging but achievable. She was able to use her professional judgement to make decisions. She would only undertake services such as MURs that were clinically appropriate.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy provides a secure environment for people to receive healthcare. But the pharmacy does not resolve maintenance issues promptly. The fixtures and fittings are dated and people can enter the dispensary easily. The pharmacy has a soundproofed room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was located in a shopping precinct next to a supermarket in Plymouth. There was a small and cluttered retail area which led to a healthcare counter and a raised dispensary. There was no distinguishable waiting area, meaning the pharmacy was frequently filled with people standing queuing and waiting for prescriptions. As there was little space, there were crates of stock waiting to be put away stacked on the shop floor, which caused obstructions and trip hazards.

The dispensary was generally well organised and stock was stored neatly on shelves. Bench space for dispensing was very limited. The fixtures and fittings were dated. Some drawers had no fronts and were opened by pulling attached cable ties. Lots of the plastic shelf edge strips in the retail area of the pharmacy were broken. The manager said that a customer had recently caught her clothing on the sharp edges. There was no barrier in place to prevent people from entering the dispensary. The RP had recently reported an incident when a person had entered the dispensary and acted aggressively when there was an issue with their prescription. The manager said that there was no planned maintenance despite reporting various problems. The area around the sink smelt strongly of damp and was unpleasant. The manager said that the pipes had been flushed but that it had not resolved the issue.

The pharmacy had a consultation room that was clearly advertised. It was of an adequate size and was soundproofed to allow conversations to take place in private. It was secured with a digilock when not in use. Prescriptions awaiting collection were stored on numbered shelves behind the healthcare counter. But the position of the shelves used to store completed prescriptions meant that peoples' private information was clearly visible to people standing at the counter. The shelves were very full and team members were seen to struggle to locate prescriptions.

Lighting was appropriate and the temperature was satisfactory for the provision of healthcare and the storage of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy is accessible and advertises its services appropriately. Medicines are supplied safely and the pharmacy gives additional advice to people receiving high-risk medicines. It makes a record of this additional advice to demonstrate that it has been given. The pharmacy offers a range of additional services and the pharmacy team deliver these services safely. Team members providing the services ensure that their training is up to date. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy had step-free access and was wheelchair accessible. The consultation room was also wheelchair accessible. Adjustments could be made for people with disabilities, such as producing large print labels. A hearing loop was available. A range of health-related posters and leaflets were displayed and advertised details of services offered both in store and locally. Services provided by the pharmacy were advertised in the pharmacy. The RP was accredited to provide all of the promoted services. The manager described how if a patient requested a service not offered by the pharmacy, she would refer them to other nearby pharmacies, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online. Records of signposting referrals were made on the patient medication record (PMR).

Dispensing tubs were used to store prescriptions and medicines to prevent transfer between patients as well as organise the workload. There were designated areas to dispense walk-in prescriptions and those collected from the GP practice. The labels of dispensed items were initialled when dispensed and checked.

Prescriptions containing fridge items and CDs in schedule 2 and 3 were highlighted using a pen. Prescriptions for schedule 4 CDs were annotated to highlight the 28-day expiry. Stickers were placed on the bottom of bags to indicate if there were additional items stored elsewhere, such as in the fridge. Prescriptions containing high-risk medicines or paediatric medicines were also highlighted with stickers. The RP described that she checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. Stickers were used to highlight prescriptions that had been identified by the RP as requiring additional counselling by a pharmacist. Details of significant interventions were recorded on the patient medication record (PMR). Substance misuse services were provided for approximately 10 people. The RP described how she would liaise with the prescriber or the key worker to report erratic pick-ups and to discuss any other concerns about users of the service.

The pharmacy offered flu vaccinations. The patient group directions covering these services were seen and had been signed by the pharmacists providing the service. The declaration of competence for all pharmacists administering flu vaccinations were seen. The regular pharmacist had completed training on injection techniques and anaphylaxis and resuscitation within the last two years.

The pharmacy had completed the audit of people at risk of becoming pregnant whilst taking sodium valproate as part of the Valproate Pregnancy Prevention Programme. Appropriate conversations had

been had with affected people and records were made on the PMR. Stickers were available for staff to highlight the risks of pregnancy to women receiving prescriptions for valproate. Information booklets and cards were available to be given to eligible women.

The dispensary shelves used to store stock were generally organised and tidy. The stock was arranged alphabetically. Date checking was usually undertaken regularly but the pharmacy has fallen behind. Spot checks revealed no date expired medicines or mixed batches. But two open bottles of Oramorph were stored on the shelves with no date of opening written on them, meaning that they could have been out of date. The manager said that she was confident that they had only been opened in the last few days as it was dispensed on a weekly basis. There were crates of stock on the shop floor which were waiting to be put to shelf. The top crate, which was open, contained, amongst other items, packets of diphenhydramine and Daktarin Gold cream, both of which were pharmacy only medicines and should not be on self-selection. Prescriptions containing omissions were appropriately managed, and the prescription was kept with the balance until it was collected. Stock was obtained from reputable sources including Alliance and AHH. Specials were obtained from Alliance Specials. Invoices were seen to this effect. Records of recalls and alerts were received by email and were annotated with the outcome and the date actioned. The pharmacy had segregated and returned a bottle of Zantac suspension that had been subject to a recall.

The pharmacy was not currently compliant with the Falsified Medicines Directive. Two stores in the company were piloting scanning products but the full roll-out had not yet happened. The company was registered with Securmed and eLearning packages were available for staff to complete.

The fridge in the dispensary were clean and tidy, but it was very full. The RP expressed concerns about it being overloaded. There were also some food items including milk and chocolate stored in the fridge. Records of temperatures were maintained. The maximum and minimum temperatures were within the required range of 2 to 8 degrees Celsius. CDs were stored in accordance with legal requirements. Denaturing kits were available for safe destruction of CDs. Patient returned CDs were recorded in a register and destroyed with a witness with two signatures were recorded.

Patient returned medication was dealt with appropriately, but no hazardous waste bin was seen. Patient details were removed from returned medicines to protect people's confidentiality.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It keeps these clean and tidy. Computers are used in a way that protects people's private information. But the pharmacy could do more to protect people's private information when storing prescriptions waiting to be collected.

Inspector's evidence

Validated crown-stamped measures were available for liquids, with separate measure marked for the use of controlled drugs only. A range of clean tablet and capsule counters were present, with a separate triangle clearly marked for cytotoxics. All equipment, including the dispensary fridge, was in good working order and PAT test stickers were visible, although the retest date had passed. The dispensary sinks were clean and in good working order.

Reference sources were available and the pharmacy could also access up-to-date information on the internet. Computers were positioned so that no information could be seen by members of the public and phone calls were taken away from public areas. Dispensed prescriptions were stored in a retrieval system on shelves on either side of the healthcare counter. But as described in principle one, people's private information such as their name and address could be clearly seen by other people being served at the counter.

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.