General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Cygnet View, Lakeside Retail Park, GRAYS, Essex, RM20 1TX

Pharmacy reference: 1031175

Type of pharmacy: Community

Date of inspection: 11/03/2024

Pharmacy context

The pharmacy is in a large supermarket. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. It also supplies contraceptive medicines using a patient group direction. And it sells over-the-counter medicines.

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	2.2	Good practice	Team members are given time set aside to undertake regular and structured training. This helps them keep their knowledge and skills up to date.
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 identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And it protects people's personal information. People can provide feedback about the pharmacy's services. And team members know how to protect vulnerable people. The pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. The pharmacy carried out a 'safe and legal' audit which helped to ensure SOPs were being followed, staff training was up to date and the pharmacy had undertaken its expiry date checks for dispensing stock. Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She said that she would attempt to contact the pharmacy manager and inform the pharmacy's head office if she was not able to get hold of him. The pharmacist said that team members knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and discussed openly in the team. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that there had not been any recent dispensing errors. The pharmacy had recently implemented an additional check on the medicines before being handed out. The pharmacist said that this had helped identify mistakes before items were supplied to people. The pharmacist said that he took a mental break between dispensing and checking medicines when he was working on his own.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The pharmacist explained that baskets should not be stacked more than four high to help minimise the chance of the stack falling. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The pharmacist said that he would remind team members to complete the private prescription record and emergency supply record correctly in future.

People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely when the pharmacy was closed, and team members used their own smartcards during the inspection.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The pharmacist said that there had been a recent complaint received. The complaint had been put in at the customer service desk in the store and the pharmacy had been made aware. It was primarily a customer service complaint and it had been dealt with in line with the company's policy.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Team members had undertaken training about protecting vulnerable people. The pharmacist could describe potential signs that might indicate a safeguarding concern. And he would refer any concerns to the relevant agency. He said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and one trainee dispenser working during the inspection. The trainee dispenser had already completed the medicines counter assistant training and was enrolled on a dispenser course. The pharmacist explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The pharmacy was up to date with its dispensing. The pharmacist and trainee dispenser worked well together and communicated effectively during the inspection to ensure that tasks were prioritised, and the workload was well managed. Team members wore smart uniforms with name badges displaying their role.

The trainee dispenser appeared confident when speaking with people. She asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. And she referred to the pharmacist when needed throughout the inspection. The pharmacist said that team members referred to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

Team members had access to online training modules provided by the pharmacy's head office. They undertook mandatory training and could do additional training modules if they wanted. The pharmacist said that team members were given regular protected training time so that they could complete the training during work. Team members had recently completed training for the Pharmacy First service. The pharmacist said that he routinely monitored staff training to ensure that it had been completed within the required timeframe. And the pharmacy's head office would contact the pharmacy if it was not up to date with its training. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And he felt able to make professional decisions. He had recently completed online training for the flu vaccination service which included basic life support. Targets were set for the New Medicine Service and Pharmacy First. The pharmacist did not feel under pressure to achieve the targets and he provided the services for the benefit of people using the pharmacy.

The pharmacist explained that team members had yearly performance reviews. There were regular pharmacy team meetings and the pharmacy received weekly newsletters from its head office with important information such as regulatory updates. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said that the area manager visited the pharmacy regularly. And there was a weekly conference call with other pharmacy managers in the area. company.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

The consultation room was accessible to wheelchair users and was in the shop area next to the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were available in the main store and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

The pharmacy was at the back of the store and there was step-free access to the pharmacy counter. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. The pharmacy could produce large-print labels for people who needed them. The pharmacy offered the Pharmacy First service on a walk-in basis and an appointment was not needed. The pharmacist explained that people were not always able to wait for the pharmacist to become available, so they were provided with a QR code which allowed them to view available appointments at this pharmacy and other local ones in the company. The pharmacist said that the pharmacy offered appointments when there was extra staff working so that cover could be provided.

There were signed in-date patient group directions available for the relevant services offered. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. And it was recorded on a person's medication record if they were in the at-risk group and on the Pregnancy Prevention Programme. The pharmacist said that he would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next several months were marked. There were no date-expired items found in with dispensing stock during a spot check and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and maximum and

minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. An alarm sounded on the fridge it the door had been left open and the door was locked when the pharmacy was closed.

The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around six weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids and triangle tablet counters were available and clean. A separate tablet counter was marked for cytotoxic use only and this helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer’s guidance. And the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where 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.