

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, New River Trading Estate,
Brookfield Centre, Cheshunt, WALTHAM CROSS, Hertfordshire, EN8
OTA

Pharmacy reference: 1032379

Type of pharmacy: Community

Date of inspection: 25/10/2022

Pharmacy context

The pharmacy is in a supermarket. It provides NHS and private prescription dispensing mainly to local residents, as well as flu vaccinations in season and the New Medicines Service. Several people are supplied with medicines in multi-compartment compliance packs. The pharmacy also provides a supervised consumption service for people treated by the drug and alcohol team.

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

Members of the pharmacy team work to professional standards and identify and generally manage risks effectively. The team members are clear about their roles and responsibilities. They log any mistakes they make during the pharmacy processes. And they learn from these to avoid problems being repeated. The pharmacy generally keeps its records up to date. It manages and protects information well and it tells people how their private information will be used. The team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that were offered by the pharmacy. The pharmacy's team members said they had been read. Services were risk assessed, and the regular pharmacist had stopped the flu vaccination service, as he was off sick and the other regular pharmacist was about to go on maternity leave. The procedures said the team members should log any mistakes in the dispensing process to learn from them. They regularly logged mistakes which had not left the pharmacy and they had regular meetings to discuss trends and learning from these. Similar looking and sounding medicines (LASA) were separated on the shelves.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles, and they were observed asking the pharmacist for advice, when needed.

The pharmacy team recorded private prescriptions and emergency supplies on the computer, but the details of the date of the prescription and the name and address of the prescriber were not always recorded accurately. The controlled drugs registers were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries.

Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. Confidential waste was separated into bags and disposed of by a licensed waste contractor; filled bags were stored securely before collection. Access to the NHS database was robust, with staff seen to remove their access cards when not using the computers.

The pharmacist had undertaken level 2 training about safeguarding and the whole team had done company training on the subject. There were local telephone numbers for the safeguarding boards available for use if needed. The pharmacy had professional indemnity and public liability insurances in place.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy currently has enough qualified staff to provide safe services though upcoming changes to the team may impact this. Training is provided by the company and staff find this useful to help keep their skills and knowledge up to date.

Inspector's evidence

There were two regular pharmacists, but one was off sick and the other about to go on maternity leave. There was a regular locum pharmacist and two dispensers working in the dispensary on the day of the inspection as well as a counter assistant. The locum had explained, in detail, to the staff what she required them to do and was seen supporting them when they were talking to patients. The counter staff were seen to use a specific questioning technique when asking people about their requested medicine purchases. This was to help make sure they got all the information they needed so that the sales were safe and appropriate. The dispensary workload was organised with the team members dividing the tasks and changing their jobs regularly so that they all worked efficiently.

Staff were given training and said that they were up to date with this. They were not given protected time to do this work. Topics covered had included general subjects such as safeguarding, and timely reminders such as cold and flu treatments. They had regular appraisals.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was situated at the rear of the supermarket. The consultation room was to one side, accessible from the main store. This room was clean, tidy and bright with space for the less able to access it. There were two chairs and a table in the room. Sharps were stored appropriately.

The dispensary was clean, bright, tidy and large enough for the volume of work. It was generally well ordered, with separate areas for dispensing and checking prescriptions. The storage equipment was in good order. The counter was protected by a screen to help prevent the spread of COVID-19, and access to the dispensary and counter was through a locked gateway.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy gets its medicines from reputable sources. And pharmacy team members plan extra services around the staffing levels, to make sure that dispensing routines are not affected. However, the pharmacy could do more to make sure people who receive higher-risk medicines, including valproate, get all the information they need so that they can use their medicines safely.

Inspector's evidence

Access to the pharmacy was level from the main store. People were signposted to other services available locally when required. Flu vaccinations, when offered, were planned when there was an overlap of pharmacists, so that one could concentrate on vaccinating whilst not being distracted by over-the-counter sales and dispensing. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another during the dispensing process. Prescriptions where the person was waiting were put into red baskets to highlight this fact. Computer-generated labels included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced.

Some people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines contained in the packs. Patient information leaflets (PILs) were supplied, meaning that people could easily access the information provided by the manufacturer about their medicines. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs.

Schedule 4 controlled drug prescriptions were not always highlighted to staff who were to hand them out. This could increase the chance of these items being given to people more than 28 days after the date on the prescription. Prescriptions for warfarin, lithium or methotrexate were not flagged by the team. And the staff said they did not always notice the medicine and ask the relevant questions, in accordance with the standard operating procedures. So, the pharmacy could not show that it was always monitoring the patients in accordance with good practice.

The pharmacy also did not have a robust system in place when dispensing valproate to make sure that people who may be in the at-risk group would receive the right information about pregnancy prevention. The pharmacy did have appropriate warnings stickers for use if the manufacturer's packaging could not be used. And the staff were aware that they had some available and said they used them for the two people in the at-risk group. All prescriptions were handed to the dispensary team by the counter staff, before being handed out, so the people should be counselled appropriately, but the staff were not sure that this happened on every occasion. The staff said they would review the standard operating procedures for these higher-risk medicines and ensure that they followed them.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way.

There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. Fridge temperatures were recorded daily and were within the recommended range. Drug alerts were received, actioned, and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.