General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Mill Strood Road, WHITSTABLE, Kent, CT5 3EE

Pharmacy reference: 1033029

Type of pharmacy: Community

Date of inspection: 05/09/2024

Pharmacy context

The pharmacy is in a superstore in a largely residential area near the seaside town of Whitstable. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and blood pressure checks.

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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risks.
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	4.1	Good practice	The pharmacy reaches out to the local community to encourage people to access its services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. And it regularly seeks feedback from people who use the pharmacy. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help reduce risks and make its services safer. The pharmacy protects people's personal information well. Team members understand their role in protecting vulnerable people. And it largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and the team's roles and responsibilities were specified in them. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. They said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They explained that they would attempt to contact the pharmacist and inform the duty manager if needed. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy recorded near misses, where a dispensing mistake was identified before the medicine had reached a person. These mistakes 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. The pharmacy regularly reviewed its near miss record for any patterns. And the outcomes from the reviews were discussed openly with 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. A recent error had occurred where the wrong type of medicine had been supplied to a person. The pharmacist said that the packaging for the medicines involved had looked similar, so team members had been reminded to check that the product name was the same as the medicine on the prescription. And to also ensure that medicines were checked and put away in the right place when the orders were received.

Workspace in the dispensary was free from clutter and baskets were used to minimise the risk of medicines being transferred to a different prescription. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Team members initialled 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 recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist said that people were referred to NHS 111 if they needed a prescription-only medicine in an emergency without a prescription. The private prescription records were largely completed correctly, but the correct prescriber and the appropriate date on the prescription was not always recorded. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there were a few of occasions recently when the pharmacist had not completed the record when they had finished their shift and a different pharmacist was working the

following day. The importance of maintaining complete records about private prescriptions and the RP record was discussed with the team during the inspection.

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

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 not been any recent complaints. He explained that he would attempt to address any complaints and inform the pharmacy's head office. Team members said that the pharmacy would be informed if a complaint had been made directly to its head office. Customer feedback cards were available at the pharmacy counter for people to take. People could use the barcode on the card to provide feedback about the services they had received. The pharmacist said that he regularly accessed the feedback online and shared it with the team.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. The trainee MCA knew potential signs that might indicate a safeguarding concern and would refer any concerns to one of the pharmacists. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns, make suggestions, and make professional decisions. And team members do not let the pharmacy's targets affect their professional decisions.

Inspector's evidence

There was one pharmacist, two trained dispensers and one trainee MCA working at the start of the inspection. A second pharmacist and trainee MCA started their shift part way though the inspection. The second pharmacist said that there was a handover period between the pharmacists so that they could discuss any issues. There were contingency arrangements for pharmacist cover if needed. And team members explained that holidays were staggered to ensure that there were enough staff to provide cover. Team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised. The pharmacy was currently several days behind on its repeat prescriptions. Team members explained how the pharmacy managed this and there was a clear system to enable them to easily find a prescription so it could be dispensed promptly when a person came to collect their items. There were no large queues seen during the inspection. And people were able to present their new prescriptions and get them dispensed while they waited.

The trainee MCAs appeared confident when speaking with people. And they asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. One, when asked, was aware of the restrictions on sales of pseudoephedrine-containing products. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

The pharmacists were aware of the continuing professional development requirement for professional revalidation. They had completed declarations of competence and consultation skills for the services offered and had done the associated training. And they felt able to make professional decisions. Team members had recently completed training about the Pharmacy First service. They explained that they had to do regular mandatory training from the pharmacy's head office, including training about health and safety and the sale of age-restricted products. A dispenser said that she could complete the training at work but preferred to do it at home. Team members said that they could use an office in the staff areas in the store if needed.

Team members said that they had informal morning huddles to discuss any issues and allocate tasks. Team members explained that most of the team worked on a part-time basis. The pharmacy used a group chat to share important pharmacy-related information and discuss issues. A team member confirmed that no patient identifiable information was shared in the group chat. Team members said that the area manager regularly visited the pharmacy to undertake internal audits and discuss any issues and the targets. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they said that they had ongoing informal performance reviews.

Targets were set for the New Medicine Service, the Pharmacy First service and the blood pressure (BP) service. Team members said that the pharmacy usually me the BP service target. The pharmacist said that he would not let the targets affect his professional judgement. And the pharmacy provided the services for the benefit of the people using the pharmacy.

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 against unauthorised access. Pharmacy-only medicines were kept behind the counter and blinds were used to cover them when the pharmacy was closed. 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. The pharmacy was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines.

The pharmacy had undergone a re-fit around six months ago. The pharmacist said that this had created additional workspace for dispensing. And the pharmacy now had a room next to the pharmacy to store bulky items and additional stock. There was seating in the shop area for people to use while waiting for services. The consultation room was accessible to wheelchair users and was in the shop area. 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 store area and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services and the pharmacy reaches out to the local community to promote its services and make them more accessible. 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.

Inspector's evidence

There was step-free access to the pharmacy counter and the main entrance to the store had wide automatic doors. Services and opening times were clearly advertised, and a variety of health information leaflets was available. Part of the medicines counter was at a level suitable for wheelchair users. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels for people who needed them. The pharmacist explained that the pharmacy was participating in a community event outside the store. People would be invited to have their blood pressure checked and receive advice from the pharmacy team. Following the event, the pharmacy confirmed that it had been a success and the pharmacy had managed to carry out several blood pressure checks for people that fitted the criteria. And it had also carried out several more for people who did not fit the criteria. During the event, the pharmacy had also made people aware of the pharmacy's text messaging service, flu vaccination programmes, the Pharmacy First service and blood pressure checks.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy dispensed these medicines in their original packaging. The pharmacist said that he would refer people to their GP if they needed to be on the PPP and weren't on one. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he routinely checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not always kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

Stock was stored in an organised manner in the dispensary and items with a short shelf life were highlighted. Expiry dates were checked every three months and this activity was recorded. There were no date-expired items found in with dispensing stock during a spot check and medicines were kept in their original packaging. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, the MHRA, the pharmacy's head office and the wholesalers. 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 which made it easier for the pharmacy to show what it had done in response.

The fridges in the dispensary were suitable for storing medicines and were not overstocked. Fridge

temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. CDs were stored in accordance with legal requirements and 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.

The pharmacist explained that people were sent a text message to inform them that their items had been dispensed and were ready to collect. He said that people were sent regular follow-up texts to remind them about their medicines waiting collection. And items remaining uncollected after around six weeks were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. 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. And 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

The pharmacy had triangle tablet counters and suitable equipment for measuring liquids, and these were clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced yearly by the pharmacy’s head office. The weighing scales and infra-red thermometer were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacist said that the otoscope was cleaned regularly and use disposable tips were used.

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.