General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Tesco Superstore, 300 Beverley Way, NEW MALDEN, Surrey, KT3 4PJ

Pharmacy reference: 1036690

Type of pharmacy: Community

Date of inspection: 30/11/2022

Pharmacy context

A community pharmacy belonging to Tesco. The pharmacy is in a Tesco supermarket near the centre of New Malden. In addition to dispensing prescriptions and selling over-the-counter medicines, the pharmacy provides a high blood pressure detection service. And a flu vaccination service.

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	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 suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy identifies and manages the risks associated with its services. And team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy team described how its workload pressures had increased during and since the height of the pandemic. This was partly due to staff shortages. And so, to help manage the workload the pharmacy had reduced its extended opening hours. It did this with the support of line managers and the local NHS team. And it had reduced its opening hours by two hours each day from Monday to Saturday. But it maintained its Sunday opening hours. By reducing its opening hours, the pharmacy had been able to find enough staff cover as it no longer needed to find pharmacists and support staff to work the hours between 8pm and 10pm each evening. The pharmacy had also reduced its range of services. It had done this to reduce the heavy workload pressures on the team, so that it could concentrate on delivering a safe and effective dispensing service.

The team had a system for recording its mistakes. It recorded them electronically. And it reviewed them each month. The responsible pharmacist (RP) was one the regular RPs. He described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same or similar mistakes from happening again. The pharmacy's records showed what the team had learned from its near misses and any actions arising from them. A previous near miss between two similar creams had led to team members underscoring the name of both products. They did this each time they had a prescription for either one to prompt an additional check. And they did it for four weeks until it was clear that the same mistake was unlikely to happen again. They applied this process every time a near miss occurred with a medicine. Team members also made each other aware of similarly packaged items and look-alike-sound-alike drugs (LASAs) such amlodipine and amitriptyline tablets to help prevent future mistakes. And it shared learnings with other branches through a commonly used app.

The team also received a monthly 'safety starts here' newsletter from the superintendent. The newsletter highlighted areas of risk which had been identified in the wider company. And in the world of pharmacy in general. The team described how the newsletter made it aware of prescriptions for gender dysphoria which other branches had received. The article encouraged pharmacists to make all the appropriate precautionary checks, including appropriate prescriber checks before dispensing the medicines.

The team worked under the supervision of the responsible pharmacist (RP). The RP had placed his RP notice on display for people to see. The notice showed his name and registration number as required by law. The pharmacy had a set of up-to-date standard operating procedures (SOPs) for team members to follow. And to help them understand their roles and responsibilities. The dispensing assistant (DA) referred to the technician or the responsible pharmacist (RP) as appropriate when she needed more

detailed information about a prescription or a counter medicine for a customer. And in turn the technician consulted the RP when she needed his expertise on clinical issues. Dispensary staff worked alongside the RP by preparing prescriptions ready for an accuracy check.

The pharmacy sought customer feedback in several ways. It provided people with information so they could contact head office. And it listened to people's concerns. People gave feedback directly to the team, or they could pick up a customer comment card at the counter. The pharmacy provided people with details of where they should register a complaint if they needed to. And if necessary, it could also obtain details of the local NHS complaints procedure online. But it usually dealt with any concerns at the time. Recently the team had received concerns from people who were unhappy about queues which built up from time to time. It explained that this had been unavoidable during periods of staff shortages. But it also conducted a third check on prescriptions before handing them out. So, although this meant that the overall process took a little longer, it felt that the third check provided an important additional safety step. So, the team took time to explain the importance of this to people. But most people's prescriptions were ready for them when they came to collect them. As most prescriptions were regular repeat prescriptions, which the pharmacy received electronically. This meant that it could order the stock and get them ready in advance. Provided they had received the prescription from the surgery in time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record, and its private prescription records. It also had a CD destruction register for patient-returned medicines which was up to date. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy's records for emergency supplies were generally in order but some records did not give the reason for supply. The RP recognised the importance of maintaining the pharmacy's essential records so that they were up to date and complete. The pharmacy's team members understood the need to protect people's confidentiality. Confidential waste was set aside for collection and subsequent disposal by a licensed waste contractor. The pharmacy stored its completed prescriptions in the dispensary where they were out of people's view. Team members had completed appropriate safeguarding training. The RP could access details for the relevant safeguarding authorities online if they needed to. But staff had not had any specific safeguarding concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has put measures in place to ensure it manages its workload safely and effectively. And its team members support one another. Team members are comfortable about providing feedback to one another so they can maintain the quality of the pharmacy's services. Team members have the right skills and training. But while the pharmacy does not always have enough staff to manage all its workload, it puts measures in place to ensure that people still receive pharmacy services.

Inspector's evidence

At the time of inspection, the pharmacy had a technician, a trainee technician, and a DA on duty with the RP. The pharmacy also had two other regular RPs. And the three RPs covered most of the pharmacy's opening hours between them. The daily workload of prescriptions was in hand and the team dealt with people promptly. Staff had read all the relevant SOPs. And they worked effectively together. They assisted each other when required and discussing issues. And they felt supported by colleagues and line managers. The pharmacy had a small close-knit team and staff could raise concerns and discuss issues when they arose. Staff generally had regular appraisals about their work performance. And they completed regular training through the Tesco online training hub. Each member of the team had an electronic training record. And they also had their own training folders. Records showed that they had completed training on health and safety, confidentiality, safeguarding, the flu vaccination service, and sepsis. The trainee technician had also progressed well with her NVQ3 training which she had almost completed.

The RP was able to make his own professional decisions in the interest of patients. And while he had targets to meet for a selection of services, such as the flu vaccination service, he did not feel under pressure to meet them. He described how the pharmacy had been unable to open on two occasions in recent months. And on each occasion, it had closed for half a day. It had to do this due to a shortage of pharmacists. The day before each closure the team had notified its local GP surgeries. And it had notified neighbouring pharmacies. Including other Tesco pharmacies. It put a notice on display explaining the closure to people. Inviting them to return at another time or seek help from one of the other neighbouring pharmacies. It also provided contact numbers for these pharmacies.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they provide an adequate amount of space for those services. The pharmacy is sufficiently clean and secure. The team keeps its workspace and storage areas appropriately tidy and organised.

Inspector's evidence

The pharmacy had screens on top of its counter and at the prescription reception counter to help protect people from the transfer of infections. A cleaner cleaned floors and surfaces once a week when staff were present to supervise. And the team cleaned the pharmacy's work surfaces and contact points twice daily. And it kept the premises tidy, organised, and well maintained. The pharmacy had a long counter which had a backwall behind it for displaying its over-the-counter medicines. The counter had a half height gate with a keypad entry system at one end. This allowed staff to move in and out of the pharmacy while preventing unauthorised access. The consultation room was signposted. And it had access from the customer area. The consultation room was clean and tidy. And it had locked cupboards for storing paperwork with confidential information. The consultation room was big enough for the services provided. And staff kept it locked when it wasn’t in use to prevent unauthorised access. The pharmacy had a small seating area for anyone waiting.

The dispensary was behind the counter medicines back wall. Its layout was suitable for its activities. And it provided enough space for the team to work safely and effectively. It had a clear workflow, and it had distinct areas for different dispensing and checking activities. It also had a ‘U’ shaped section which provided a more secluded area. And staff could work here with fewer interruptions from people. The dispensary had workbenches along two sides with storage areas above and below. It also had a run of pull-out drawers and shelves for storing medicines and completed prescriptions awaiting collection. The pharmacy stored its dispensed items and prescriptions so that it kept people’s information out of view. And it stored its medicines in a tidy, organised way. People could not view the pharmacy’s dispensing benches from the customer area. And this meant that the team kept people’s prescription information confidential. Team members in the dispensary could oversee the counter. And so, they could help their colleagues when the counter got busy. The dispensary work surfaces and floors were tidy. Overall, the pharmacy was well lit and ventilated with temperature control systems in place. And it was suitable for the provision of healthcare services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures help ensure it provides its services safely. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use and protect people's health and wellbeing. The pharmacy team supplies medicines with information that people need. So, they can take their medicines properly and safely.

Inspector's evidence

The pharmacy was close to the general healthcare area within the supermarket. And it had a large green pharmacy cross sign above it to help people find it. The main store entrance had large double automatic doors which provided step-free access from outside. This made access easier for wheelchair users and those with mobility difficulties. The pharmacy displayed its opening hours and information about its services on the wall outside the pharmacy.

And it had a small range of information leaflets for people to take away. The retail area and consultation room were free of obstructions. So, they were suitable for wheelchair users. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to prevent errors by keeping medicines together with the prescriptions they belonged to. Team members used stickers to identify any completed prescriptions containing controlled drugs (CDs) so they could remove them from storage after their prescription's 28-day expiry date. This was important for all CDs including prescriptions containing schedule 4 CDs. The stickers also identified CDs which the team had stored appropriately elsewhere so that staff could locate them easily. The team also used 'Fridge' stickers to identify prescriptions which had items stored in the fridge, so that they did not leave any items behind when transferring people's prescriptions to them.

The RP gave people advice on a range of matters. And he explained how he gave the appropriate advice to anyone taking higher-risk medicines. The pharmacy dispensed prescriptions to a few people taking sodium valproate medicines. And so, it had taken part in the recent NHS audit of valproate products. The results showed that the pharmacy did not supply valproate medicines to anyone in the at-risk group. But the RP described the counselling he would give when supplying the medicine to an at-risk person to ensure that they were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets. The pharmacy offered an asthma intervention service. Through the service it had identified several people who were not using a preventative inhaler. And used a reliever inhaler only. After counselling those individuals, the pharmacist referred them back to their GP to have a preventative inhaler prescribed. The pharmacy also offered a flu vaccination service. It had up to date PGDs and service specifications for both the private and NHS flu service. In general, the RP briefed the person receiving the vaccination appropriately, and asked for their consent. The RP sanitised or washed his hands before and after each consultation. And he discarded used vaccines safely into a sharps bin. The RP kept records of the consultation for each vaccination. This included details of the product administered. The pharmacy had procedures and equipment for managing an anaphylactic response to vaccinations.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate

licences. The team stored its medicines appropriately and in their original containers. Stock on the shelves was tidy and organised to assist selection of the correct item. The pharmacy team date-checked the pharmacy's stocks regularly, checking a different section each time. And it identified and highlighted any short-dated stock. A random sample of stock checked by the inspector was in date. Team members kept records to help them manage the process and to show what they had checked and when they had checked it. And they put any out-of-date and patient returned medicines into dedicated waste containers. The team stored fridge items appropriately. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls. And it had not had any of the batches of Oxycodone 10mg/ml from the recall issued the day before.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The team had access to personal protective equipment PPE. Team members wore masks. And they cleaned work surfaces and equipment regularly. The pharmacy had two computer terminals. It had one in the dispensary which had a patient medication record (PMR) facility. And it had another one in the consultation room which it used for its non-prescription services. Computers were password protected to prevent unauthorised access. And team members used their own smart cards when working on PMRs, so that they could maintain an accurate audit trail and ensure that access to patient records was appropriate and secure. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.