General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tesco Instore Pharmacy, Ropes Drive, Kesgrave, IPSWICH, Suffolk, IP5 2FU

Pharmacy reference: 1037189

Type of pharmacy: Community

Date of inspection: 16/11/2022

Pharmacy context

The pharmacy is located in a superstore in a largely residential area. And it receives most of its prescriptions electronically from a local surgery. It provides a range of services, including the New Medicine Service, the flu vaccination service and a stop smoking service. It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their 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	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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information well. And people can feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy mostly keeps its records up to date and accurate. And team members record and review their mistakes so that they can learn and make the services safer.

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. 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 reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Learning points were also shared with other pharmacies in the group. Quetiapine and quinine were now separated due to near misses with these medicines. 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 strength of medicine had been supplied to a person. These strengths were now kept separated to help minimise the chance of a similar mistake. One of the pharmacists said that the pharmacy had a weekly conference call with all of the Tesco pharmacies in the area. And any incidents or errors were discussed during the call.

There was limited workspace in the dispensary. Team members ensured that there was enough clear workspace available to carry out dispensing and checking tasks. And 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 team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. One of the dispensers knew which tasks she should not undertake if the pharmacist had not turned up in the morning. And she knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

There were signed in-date patient group directions available for the relevant services offered. The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. And there were some private prescriptions for schedule 2 CDs which had not been sent to the appropriate authority. One of the pharmacists said that these would be sent promptly and he would remind team members that these needed to be sent off monthly. 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. This could make it harder for the pharmacy to show why the medicine was

supplied if there was a query. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running balances were checked regularly. But the address of the supplier was not always recorded. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was largely completed correctly. There were alterations made to the RP record. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to rely on the accuracy of these records in the future.

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

One of the dispensers said that she would refer any complaints or concerns to the pharmacist on duty or to the store manager. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The team were not aware of any recent complaints.

Team members had completed training about protecting vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. One of the pharmacists said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. One of the pharmacists gave an example of action they had taken in response to safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of 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. Team members can raise any concerns or make suggestions. And they can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists, two trained dispensers and one trainee dispenser working at the start of the inspection. The pharmacist's shifts overlapped so that they had time to hand over any tasks that needed completing or to discuss any issues. The RP handed over responsibility to the second pharmacist part way through the inspection when he had finished his shift. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role. One of the pharmacists said that two pharmacy technicians and one dispenser had recently left and had not been replaced. Some team members were currently working overtime to ensure that the daily tasks could be completed. The pharmacy's head office had been made aware. One of the dispensers said that the pharmacy was around one day behind with its dispensing tasks. The pharmacy had a system so that prescriptions could easily be found if a person presented to collect their medication and it had not been dispensed prior to this.

Team members appeared confident when speaking with people. One of the dispensers was aware of the restrictions on sales of products containing pseudoephedrine. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

One of the dispensers explained that team members received training modules from the pharmacy's head office. But these had to be completed in their own time at home as there was not enough spare time during their shifts. The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. Team members had been undertaking training as part of the Pharmacy Quality Scheme, including about asthma and cancer awareness. And team members were due to complete training about risk management and sepsis. The pharmacists had completed declarations of competence and consultation skills for the services offered, as well as associated training. And they felt able to take professional decisions.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. There were no regular meetings as most of the team worked part time. Team members had ongoing informal reviews of their performance and a formalised appraisal every six months. Targets were set for the New Medicine Service and the team felt under a certain amount of pressure to achieve the targets. The pharmacist said that he would not let the targets affect his professional judgement and he carried out the service for the benefit of the people using it.

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 and this presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. 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.

There were two chairs in the shop area which were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located next to the pharmacy in the store 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 main store staff area and separate hand washing facilities were available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. 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. And it dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access to the pharmacy through the shop area. The pharmacy was at the far-left corner of the store and it was well signposted. 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.

Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. 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. And if a person who needed to be on one was not, he would refer them to their GP. The pharmacy had the relevant patient information leaflets and warning cards available. But not the additional warning stickers for use with any split packs. The pharmacist said that he would order these from the manufacturer. 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 checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 were highlighted but not prescriptions for schedule 4 CDs. This could increase the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that he would ensure that these prescriptions were highlighted in future.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were marked. And the pharmacy kept lists of short-dated items so that these could be easily identified and removed from dispensing stock before they were had expired. There were no date-expired items found in with dispensing stock. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and it was not overstocked. One of the pharmacists explained that if the temperature was found to be outside the recommended range, he would inform the store manager and the pharmacy's head office.

Part-dispensed prescriptions were checked frequently and prescriptions for alternate medicines were requested from prescribers where needed. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions were kept at the

pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked every six weeks, and people were sent a text message reminder if they had not collected their items. If the items remained uncollected for a further two weeks, the prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested and people contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

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 segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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.

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 was available. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. 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 had been in use since February 2019 and this was written on the machine. One of the dispensers said that she would check the manufacturer's guidance, speak with the pharmacist, and arrange for it to be replaced if needed. The carbon monoxide testing machine was calibrated by an outside agency and the weighing scales appeared to be 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.